

REMOVING SERIOUSLY ILL ASYLUM SEEKERS FROM AUSTRALIA

A COLLABORATIVE PROJECT BETWEEN THE REFUGEE HEALTH
RESEARCH CENTRE LA TROBE UNIVERSITY AND THE ASYLUM
SEEKER PROJECT AT HOTHAM MISSION

JULY 2007

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Refugee Health Research Centre La Trobe University

The Refugee Health Research Centre (RHRC) contributes to improving access to health and social services for refugees and asylum seekers and informing strategies for promoting participation and social inclusion in Australian society. Established in 2003, the RHRC also builds public awareness and contributes to community debate about issues relating to refugee health and settlement both in Australia and around the world.

Established as part of the Faculty of Health Sciences at La Trobe University, the RHRC receives funding from the University and through research grants from a number of other sources. In January 2007, the RHRC moved from the Faculty of Health Sciences to become part of the Faculty of Humanities and Social Sciences at La Trobe University.

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Asylum Seeker Project, Hotham Mission

The Asylum Seeker Project, based at Hotham Mission in Melbourne, Australia, works with asylum seekers in the community lawfully awaiting an outcome on their refugee or humanitarian claim, yet denied the right to work, welfare payments or public health care.

The Asylum Seeker Project has for the past ten years provided a comprehensive range of care programs for vulnerable asylum seekers, including free housing, casework, volunteer assistance, support programs, payment of emergency costs and provision of monthly cash relief. The Asylum Seeker Project aims to provide the highest standard of care to asylum seekers, while ensuring advocacy for the rights of asylum seekers in Australia.

The Asylum Seeker Project receives no federal government funding and relies on the broader community, church and philanthropic sector for support.

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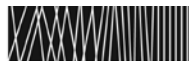
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Lewis Holdway

L A W Y E R S

Acronyms

ASAS	Asylum Seekers Assistance Scheme
BVE	Bridging Visa E
DIAC	Department of Immigration and Citizenship*
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOM	International Organization for Migration.
MSI	Migration Series Instruction
PAM	Procedures Advice Manual
RPBV	Return Pending Bridging Visa
RRT	Refugee Review Tribunal
THV	Temporary Humanitarian Visa
TPV	Temporary Protection Visa
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees

* Prior to 30 January 2007, DIAC was known as the Department of Immigration and Multicultural Affairs (DIMA).

Executive Summary

RECENT CHANGES

During the course of this research the Department of Immigration and Citizenship (DIAC) has been through some major changes in response to a series of government inquiries into the Department's policies and operation. As a result, the Department has embarked on a process of substantial change. Some of the issues prompting this research have since been acknowledged and are being addressed by DIAC. We welcome these changes and offer our support to the Department as it continues to implement more constructive approaches towards asylum seekers in Australia.

While there has been an increasing awareness of issues relating to the removal of vulnerable persons from Australia, the fundamental concerns identified by the research remain valid at the time of writing. In particular, core policies and practice relating to the removal of seriously ill asylum seekers have remained largely unaltered. We hope this report will draw attention to specific areas still needing urgent attention and in doing so, contribute to the Department's ongoing process of change.

REMOVING SERIOUSLY ILL ASYLUM SEEKERS

Asylum seekers go through an extensive assessment process in Australia. Those who are found not to be refugees are removed from Australia by process of law. For those who are seriously ill, removal¹ is a particularly distressing event, leading to a future heavy with the suffering of untreated or under-treated illness.

Removal is a practice undertaken by most Western countries as a traumatic but necessary component of a fair and reliable asylum assessment system. However, in some cases the Australian government has pursued removal outcomes with a serious disregard for the health and wellbeing of removees. In particular, there has been a lack of concern for the welfare of asylum seekers² who are facing removal despite suffering a serious illness. This research, conducted by the Refugee Health Research Centre (La Trobe University, Melbourne) and the Asylum Seeker Project at Hotham Mission (Melbourne), is the first comprehensive study examining the issues surrounding the removal of asylum seekers who are seriously ill³.

The study found that current Australian policy and practices lack adequate consideration of health and welfare issues for seriously ill asylum seekers at all stages of the asylum process. In addition, it found that the asylum process in Australia contributes to the deterioration of the mental and physical health of those being processed. This impact on health is linked to the processes themselves, as well as to the specific limitations placed on asylum seekers' access to health care and basic resources.

This strong association between ill health and the asylum process in Australia is counterproductive to a smooth transition from the end of the asylum assessment process to either return or residency. This association has significant implications when considering the practical and moral dilemmas involved in removal. It also introduces greater levels of responsibility for the future health of asylum seekers in countries of return.

Australia must ensure its practices, policies and legislation are not detrimental to the health and wellbeing of asylum seekers. Removal should be a last resort once all opportunities to enable voluntary return have been exhausted. In addition, plans to implement removal should be reconsidered for seriously ill individuals who have no prospect of ongoing care on return.

¹ The term 'removal' has been chosen to be used in this report rather than either return or deportation. It reflects the underlying state power involved in ensuring people who no longer have a valid visa leave Australia.

² The term 'asylum seeker' is used throughout this report to refer both to individuals who are waiting for their refugee status to be determined, as well as for people who have sought asylum in Australia and have been found not to be a refugee, some of whom may be awaiting a decision on their humanitarian claim. 'Failed asylum seeker', 'rejected asylum seeker' or 'refused asylum seeker' are terms often used to refer to this latter group of people. The term 'asylum seeker' was chosen to simplify the language of the report.

³ Please see section 1.6 for the definition of serious illness used for this research.

IMPACT OF SEEKING ASYLUM IN AUSTRALIA ON HEALTH

Australia has one of the healthiest populations in the world (with the exception of the indigenous population), and maintains a comprehensive and admirable health care system. Despite this, the health of asylum seekers is at risk during the asylum process in Australia. The research identified numerous ways in which the asylum process in Australia contributes to the onset and deterioration of illnesses among asylum seekers. The issues which have most impact are:

- **Length of time waiting in uncertainty**
- **Limited access to health care**
- **Restricted access to work rights, basic income and housing**
- **Lack of support and advice**
- **Long term, indefinite detention.**

The evidence shows that asylum seekers' right to health is left largely unfulfilled during much of the asylum process in Australia. Australia fails to fulfil this responsibility in multiple and varied ways: some policies and practices cultivate ill health; some policies and practices limit or prevent the treatment of ill health; and some policies fail to prevent ill health. This situation is particularly deplorable when the ensuing health issues cannot be treated in countries of return.

CREATING HEALTHIER SOLUTIONS FOR SERIOUSLY ILL ASYLUM SEEKERS

Current removal policies do not demonstrate an appropriate level of care for asylum seekers who are seriously ill. Removals have been undertaken and attempted with a lack of concern for removees who are suffering from mental or physical illnesses. In particular, the federal government has neglected to:

- **Adequately address health and welfare issues during removal**
- **Make appropriate arrangements for support on arrival**
- **Make use of options to delay or abandon removal on compassionate grounds**
- **Take responsibility for the long term health impact of Australia's asylum policies.**

The recommendations of the research outline opportunities to establish more compassionate responses to those with a serious illness without compromising the Federal government's control over the movement of people to and from Australia. These recommendations are designed to:

1. Improve the current levels of health amongst asylum seekers who have completed the asylum application process;
2. Ensure that more comprehensive assessments of health and welfare are incorporated in decisions regarding removal;
3. Minimise the impact of the removal process on the health and wellbeing of removees.

CONCLUSION

In an ideal world, the complex and confronting situation of removing individuals who are seriously ill to places that cannot adequately care for them would never arise. However, global inequalities in health, wealth and security are historical realities that will continue to haunt those who are aware of the tragedies that befall the less fortunate around them. The current system means that this tragic reality is compounded by the actions of the Australian government. Removing asylum seekers who are seriously ill is a painful but necessary consequence of government policy. Removing those whose illness has been cultivated, or even induced, by the actions of the government while processing the application for asylum is an abhorrent neglect of responsibility. There is, however, an important opportunity now for DIAC to review its removal policies in line with recent Departmental changes which support the health of asylum seekers. This report hopes to provide important insights into areas of policy and practice which might be amended to further this improved stance towards seriously ill asylum seekers in Australia.

Recommendations

DETENTION PAGE 16

To limit the impact of detention on the health of asylum seekers, we recommend:

- 4.2.1 Introducing an administrative or judicial review mechanism to ensure time limits on immigration detention are set.
- 4.2.2 Making greater use of bridging visas with connected entitlements to allow the release of identity, health and security cleared detainees into the community.
- 4.2.3 Ensuring the quality and availability of health care in detention centres.
- 4.2.4 Introducing specific strategies to change staff attitudes towards detainees including training in managing individuals with serious mental health concerns.

BRIDGING VISA CONDITIONS PAGE 20

To limit the impact of bridging visa conditions on the health of asylum seekers, we recommend:

- 4.3.1 Ensuring basic needs, including income, housing and health care, are met throughout the asylum process.
- 4.3.2 Ensuring work rights are available to asylum seekers throughout the entire asylum process.
- 4.3.3 Ensuring access to Medicare throughout the entire asylum process.
- 4.3.4 Limiting the time to process asylum claims at all stages.

OFF-SHORE PROCESSING PAGE 25

To decrease the impact of off-shore processing on the health and wellbeing of asylum seekers, we recommend:

- 4.4.1 Ending the use of off-shore processing by recognising all of Australia as part of the migration zone and processing all asylum claims onshore.

Notwithstanding recommendation 4.4.1, we also recommend:

- 4.4.2 Introducing an administrative or judicial review mechanism to ensure time limits on off-shore detention are set.
- 4.4.3 Making greater use of bridging visas with connected entitlements to allow the release of off-shore detainees into the Australian community for health reasons.
- 4.4.4 Increasing the quality and availability of health care in off-shore processing centres.
- 4.4.5 Ensuring supported access to legal advice.
- 4.4.6 Ensuring asylum seekers found to be refugees are offered permanent protection in Australia.

AIRPORT SCREENING OUT PAGE 27

To reduce the possibility of the airport screening process leading to *refoulement*, we recommend:

- 4.5.1 Increasing the transparency and accountability of the airport arrival screening process.
- 4.5.2 Promoting the use of a legal advisor during compliance interviews.

PRIMARY DECISIONS PAGE 29

In order to improve decisions at the primary level, we recommend:

- 4.6.1 Strengthening the quality, integrity and consistency of primary decisions.
- 4.6.2 Training officials on the effects of the refugee experience on individuals.
- 4.6.3 Establishing a consistent DIAC staff culture of objective compassion and respect, and ensuring sensitive interactions with clients.

REFUGEE REVIEW TRIBUNAL PAGE 32

To improve RRT decisions and to promote better care of asylum seekers through the review process, we recommend:

- 4.7.1 Ensuring all RRT members make use of the Tribunal's new guidelines regarding credibility.
- 4.7.2 Establishing more reliable information sources regarding the situation in countries of origin.
- 4.7.3 Meeting the 90 day standard for Tribunal decisions.
- 4.7.4 Training RRT officials on the effects of the refugee experience on individuals.
- 4.7.5 Establishing a consistent RRT staff culture of objective compassion and respect, especially in the interview situation.

MINISTER'S DISCRETIONARY POWERS PAGE 35

To increase the effectiveness of Ministerial decisions in dealing with humanitarian and compassionate issues, we recommend:

- 4.8.1 Creating a system of 'complementary protection' so that human rights issues and humanitarian concerns can be assessed at an earlier stage of the process.
- 4.8.2 Strengthening the quality and consistency of Ministerial decisions.
- 4.8.3 Developing a faster decision making process for the Minister.
- 4.8.4 Providing legal advice to applicants to ensure applications contain all relevant information.
- 4.8.5 Ensuring reasons for decisions are transparent to the applicant and to the public.
- 4.8.6 Ensuring the level of health care on return is considered, especially for applicants whose health has deteriorated significantly during the asylum process in Australia.
- 4.8.7 Introducing human rights conventions into federal legislation.
- 4.8.8 Providing applicants with support for basic needs such as housing and health care while applications to the Minister are assessed.

VOLUNTARY RETURNS PAGE 43

To increase support of voluntary returns, we recommend:

- 5.1.1 Ensuring a comprehensive funding system is in place to support voluntary return without the use of detention.
- 5.1.2 Making use of reintegration packages to support returnees on arrival. This should be offered without the use of threats.
- 5.1.3 Using comprehensive case management of return.

- 5.1.4 Improving the asylum process so that returnees are well enough to deal with the practical and emotional difficulties of undertaking return.
- 5.1.5 Using detention pending removal only as a last resort once all attempts at voluntary return have been exhausted.

AWAITING REMOVAL PAGE 46

To maintain the health and wellbeing of those awaiting removal, we recommend:

- 5.2.1 Ensuring basic needs, such as income and housing, are provided while awaiting removal.
- 5.2.2 Ensuring health care is available throughout the entire asylum process.
- 5.2.3 Replacing Removal Pending Bridging Visas with a permanent solution.

FITNESS TO TRAVEL ASSESSMENTS PAGE 48

To ensure appropriate health assessments prior to removal, we recommend:

- 5.3.1 Fitness to travel should be assessed against clear guidelines and be consistent across medical practitioners. Fitness to travel assessments for removees should be equivalent to assessments made for the general Australian population.
- 5.3.2 The medical opinion of the treating physician should be considered as professional and independent evidence of health status.
- 5.3.3 The fitness to travel assessments of HSA should be monitored to ensure independence, rigour and a recognition of mental health issues.
- 5.3.4 The outcome of fitness to travel assessments should determine the amount of medication given to returnees, and the referrals required.
- 5.3.5 A 'fitness to return' assessment should be undertaken to assess health and welfare concerns.

REMOVAL PROCESS PAGE 51

To limit the impact of the removal process on the health of asylum seekers, we recommend:

- 5.4.1 Implementing case management of asylum claims all the way through the removal event.
- 5.4.2 Developing minimum standards of care for the removal process.
- 5.4.3 Developing a culture of respect and dignity towards asylum seekers amongst personnel undertaking removals, and ensuring sensitive interactions with clients.

ON ARRIVAL PAGE 56

To ensure appropriate provisions are made for the health of asylum seekers on arrival, we recommend:

- 5.5.1 Organising appropriate handover arrangements in destination country if no issues regarding safety are evident.
- 5.5.2 Ensuring removees retain control of their travel documentation when proceeding through immigration at the port of entry. Travel documentation should be withheld only as a last resort.

CONDITIONS ON RETURN PAGE 58

To ensure return is undertaken fairly and consistently and with respect for the dignity of all human life, we recommend:

- 5.6.1 Seriously ill individuals should only be returned if their condition can be reasonably managed in their country of return.
- 5.6.2 Individuals should not be returned to a country that is in the middle of war, or experiencing severe conflict and violence.
- 5.6.3 Individuals should not be returned to a country that is unable to meet the basic needs of its residents, such as after a crisis e.g. a tsunami, earthquake or during a famine.
- 5.6.4 The Minister should make greater use of his discretionary powers to grant a visa to somebody who is facing multiple and complex threats to their health on return.
- 5.6.5 The government should increase investment in development programs in countries of return.

Case studies

This section provides four case studies of seriously ill asylum seekers. The cases have been included to provide an insight into the ways in which the policies and practices described in the report play out in people's lives.

These cases are not necessarily representative of the experiences of asylum seekers in Australia. They have been chosen instead to describe a range of experiences and outcomes for individuals who are seriously ill, including:

Case study 1: Awaiting removal

Case study 2: Removed from Australia

Case study 3: No visa resolution

Case study 4: Ministerial intervention

Each case study describes the real case of an asylum seeker who has been in Australia. The case studies are based on information provided by service providers. Information in the case studies has not been changed, but some personal information or details have been omitted.

Case study 1: Awaiting removal

A woman in her early thirties arrives in Australia with her three children. Initially, they are supported by the Asylum Seeker Assistance Scheme (ASAS) run by the Red Cross. They are able to access health care, and the woman is treated for severe asthma and placed on medication.

When her application is rejected by the Refugee Review Tribunal, the health care and the support provided by ASAS ends.

She finds help from a small charitable organisation which provides housing and \$400 a month to cover their living expenses. During this time, she is badly injured in a car accident. After leaving hospital, she suffers from ongoing neck and back pain and severe migraines. She is forced to stay in bed for long periods. Her two young teenage girls take on major responsibilities including caring for their younger brother, running the household, and looking after their mother when she is sick.

She is lucky to find a doctor who looks after her for free, but she struggles to access specialist services and cover the cost of the medicine she needs. As she becomes more fragile, the physical and emotional stress of her situation takes its toll: she loses most of the hair on her body and becomes almost entirely bald. A specialist tells her it is a common symptom of severe stress and anxiety. Her son starts to express his own distress with disturbing behaviour at school and a mental health professional is called in to assist this young boy.

The woman applies to the Minister to be allowed to stay in Australia on humanitarian grounds. She outlines her fears for her children's future safety: her son is a target in a blood feud and her two teenage girls may be abducted and forced into prostitution without a male protector. Her only relatives live in Australia. Her doctors write letters of support, convinced that the lack of care available in her country would mean her health would quickly deteriorate. Although she is not afraid of dying, the woman is worried about how her children will survive without her.

She is devastated when she receives a negative decision from the Minister. As she has no money, she cannot buy the tickets needed for their departure. While they wait for passports to be issued by their country of origin, she and her children continue to live in the community on the charity of others, knowing they could be detained and removed without warning at any time.

Their distress and fear grows with each day. They have been waiting for over a year.

Case study 2: Already removed from Australia

A woman arrives in Australia on a valid visa. Despite being confined to a wheelchair, she is independent and extremely healthy. During her stay she realises she is pregnant. She becomes afraid, as the baby is not her husband's. She realises she cannot go home, as she and her baby will be stoned to death under Sharia law for her infidelity.

She hires a migration agent who submits a protection application on her behalf. As she applied more than 45 days after arrival, she is not eligible for Medicare, housing or financial support. She finds an agency that supports asylum seekers. After a lot of work, the case worker manages to find a wheelchair accessible property for her to live in for free. It is a challenge to find the money for food and basic supplies. A worker at a hospital finally negotiates for free prenatal care and hospital support during the birth.

She learns her migration agent submitted an incomplete and inaccurate application. She and her case worker try to rectify the errors and present her claim for protection clearly.

The woman is thrilled when she gives birth to a baby boy. A local maternal child health nurse rallies some *pro bono* assistance from other professionals to provide support. This small team work with her to find ways of caring for her newborn from her wheelchair.

Soon after the birth, the woman receives a negative primary decision. She attends a Refugee Review Tribunal hearing to appeal the decision. She has no legal representation so represents herself. She is incredulous that the Tribunal member does not believe she is at risk if she returns. He believes she will be safe in the south of her country. She is sure her family will find her easily and force her to the north in order to punish her as they see fit. In the wheelchair, she won't be able to escape with her baby.

After she receives a negative decision from the Tribunal, she has a physical and mental collapse, experiencing several psychotic episodes. She comes to believe her only hope to save her baby is to kill herself. She attempts suicide on a number of occasions and is hospitalised in a psychiatric ward. They do their best to treat her, but there is no medication which will take away her fears. Her baby is placed in foster care.

They apply to the Minister to intervene on compassionate grounds. She receives a rejection from the Minister quickly and is hospitalised again soon after. They apply to the Minister again, hoping the doctor's call for ongoing care will be heeded. She is sent home from hospital again to await the outcome.

One Friday night, compliance officers arrive at her house unannounced and forcibly take her and her son to a detention centre. She calls a friend the next day, who immediately comes to visit and is disturbed to find her heavily sedated. By Monday morning she has been removed from the country.

Her case worker is furious the removal has happened without her knowledge. When she goes to clean out the woman's house, she is disturbed to find evidence of a major struggle. She is upset by the sight of the baby's bottles abandoned, half-washed, in the sink. She is sad she has not been able to say goodbye. She wonders if they will be safe.

Case study 3: No visa decision made

A man in his mid-forties applies for asylum. His wife and three children are still overseas. He is placed on a Bridging Visa E, with no work rights, income support or health care. He becomes destitute and takes a job illegally in order to earn the money for food. He is detained after he is discovered working. While in detention, he experiences major stomach pains and is treated for ulcers.

He is released into the community on a Bridging Visa E after a charitable organisation provides a bond and guarantee of support so that he won't work. His case worker finds a doctor to treat him without charge. The doctor is angry with the detention centre when he realises his patient has oesophageal cancer, not ulcers. The doctor is unable to treat such a serious illness and keeps sending the man with

his support worker to local hospitals with instructions about his diagnosis and the treatment needed. The hospital staff are sympathetic, but they are unable to provide ongoing treatment⁴.

On one occasion the doctor sends the man to the local emergency department alone, knowing the hospital will have to admit him without a carer present. He is admitted and commences treatment despite the protests of the hospital's accounts department. The hospital threatens to make the case worker liable for the bill.

The man is released from hospital but his health deteriorates rapidly. His prognosis is not good. With the assistance of a lawyer, he applies for his family to visit to be with him in the last few months of his life. DIAC refuse to allow the family to come together to visit him, but agree to allow each member to come one at a time. He is angry and resentfully accepts this as the only way to say goodbye to his family.

By this stage, he has been refused at all levels of the asylum system. His case worker is shocked when DIAC suggest the man may be removed as his visa has expired. They lodge documentation confirming he is not fit to travel.

His wife arrives and is able to spend a couple of months with him. They eventually say a final farewell, and she returns home. Soon after, his 13 year old son arrives on his own. The case workers worry about this quiet young boy, who is having to cope alone with caring for his troubled and dying father. To add to the stress, this is the first time they have seen each other in seven years. The young boy leaves, and the man waits for his two remaining sons to visit.

Throughout this time, a DIAC officer calls regularly to inquire about the man's health. The case worker is upset that DIAC seems unwilling to resolve his visa situation despite clear evidence he will not be able to leave the country. She is angry that he is being forced to die in poverty and isolation, without full medical treatment or palliative care and without his family around him.

The man has a downturn after his youngest son leaves, and they negotiate for him to go back into hospital. He dies within weeks without seeing his sons to say goodbye.

Case study 4: Ministerial intervention

A grandmother in her early sixties arrives in Australia on a 6 month tourist visa to visit her only remaining family. While in Australia, she suffers a stroke and loses feeling and movement down one side of her body. She applies for, and is granted, a six month extension to her visitor's visa.

Six months later, she is still incapacitated. At an appointment, her daughter is told by DIAC the extension will be granted for another 12 months. She is devastated when a manager calls the next day to tell her the officer had been mistaken. She is told her mother must instead apply for a protection visa. As she has already been in Australia for more than 45 days, she is issued a Bridging Visa E while her application is processed. This visa means she cannot access health care or welfare support.

For two and a half years, the woman cares for her mother at home with no assistance. She relies on her own meagre disability allowance to provide for the household. Her mother rarely leaves her bed, unable to move without significant support. It is a gruelling and distressing experience for all the household.

One day, the mother has a fall and injures herself. She is taken by ambulance to a local hospital. After two days of tests, she is transferred to another hospital. They discover she has a broken hip and has suffered a heart attack as a result of the fall. During her first month in hospital she suffers another two heart attacks.

The daughter receives a bill for over \$20,000 for the ambulance trip and for the two days in the

⁴ Victoria has since directed its public hospitals to provide health care to asylum seekers without charge

first hospital. In response to legal demands, and with assistance from a support worker, they finally negotiate to pay off \$15 each week using her disability pension.

The woman's visa application is refused at all levels and she applies to the Minister for Immigration to intervene on compassionate grounds. Her doctors easily assess her as being unfit for travel. They also note in the application that she has no one to care for her in her country of return, as she has no other surviving relatives, and no resources to pay for the medical assistance she requires.

The hospital staff are horrified when a DIAC officer suggests the woman may be removed. They are angry that an elderly woman who is bedridden in hospital and clearly unfit for travel might be threatened with removal. They defend their patient and start the long process of finding a nursing home which may take her despite having no funds to pay their fees. After months of lobbying, the social worker at the hospital finds a charitable organisation who offers to pay the fees for two years.

She moves into a nursing home near her daughter. Her daughter visits every day. Both women worry constantly that she will be taken away unexpectedly and left to live out the end of her life alone.

After several years, the Minister for Immigration makes a decision and grants her a permanent visa. It has been six and a half years since she first applied for a visa. The visa is issued with the specific conditions that she may not access health or welfare support for two years. Her relief at being allowed to stay near her daughter is tempered by her sadness at her ongoing reliance on the charity of strangers.

After a year her pharmacist refuses to provide any more medication because her daughter has been unable to pay off a bill for \$1500. She is scared of facing another year without being able to access the medication she needs. Her difficulties continue.

1. Introduction

Only a small number of the world's asylum seekers seek protection in Australia. Those who do face a difficult process which alters depending on mode and place of arrival. Asylum seekers found not to need protection are removed from Australia. There is little or no information on the number of asylum seekers removed each year, nor is there any substantial information on the health status of those removed.

1.1 Introduction

There are few asylum seekers in Australia, and yet the government maintains a harsh stance towards the small numbers of people who come to Australia and ask for protection. Social and welfare support for individuals seeking asylum is limited, especially in the later stages of appeal. Asylum seekers who have been found by the government not to need our protection are removed.

Too often, the needs of asylum seekers who are seriously ill are neglected during the asylum process in Australia and at the point of removal (Asylum Seeker Project Hotham Mission, 2003; Corlett, 2007; Correa-Velez, Gifford, & Bice, 2005; Steel & Silove, 2000).

This research was undertaken to investigate the tensions between the right to health and government policies and practices relating to the health care needs of asylum seekers who are seriously ill and are facing removal. It incorporates the cases of refused seriously ill asylum seekers in a broader analysis of the policies and practices of the Australian government and other resettlement countries. These practices are compared with a number of international human rights conventions. The research was developed in response to the concerns of a number of asylum seeker organisations that feared for the future health of clients with serious illnesses who were being removed to countries that could not provide adequate medical care.

1.2 Refugees and asylum seekers

An asylum seeker is someone who feels they are being persecuted in the country where they live, and has left that country to seek protection from that persecution. Protection is limited in many countries of asylum to those individuals who fit within the definition of a 'refugee' found in the 1951 *Convention Relating to the Status of Refugees* ("Refugee Convention"). This international convention identifies a refugee as someone who:

...owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country...

The Refugee Convention, and the related 1967 *Protocol Relating to the Status of Refugees*, sets out the agreement between all states who are party to the Refugee Convention regarding the treatment of refugees in their territory.

1.3 Numbers of asylum seekers in the world

In 2005, 668,000 people around the world applied for asylum for the first time, adding to the 856,700

people whose applications were pending (United Nations High Commissioner for Refugees, 2006). Table 1 shows the number of asylum applications in 2005. The table includes the five countries with the highest numbers of new applications in 2005, the nine traditional UNHCR resettlement countries and some selected countries from within the Pacific region.

TABLE 1: ASYLUM APPLICATIONS BY COUNTRY OF ASYLUM, 2005

Adapted from 2005 *Global Refugee Trends* (United Nations High Commissioner for Refugees, 2006)

	Applications pending (start of 2005)	Applied during 2005	Recognised	Rejected	Pending end-2005
France	11,600	97,784	22,145	85,275	11,700
United Kingdom	9,700	52,079	8,436	50,393	13,400
Thailand	1,044	47,714	719	736	32,163
Germany	100,841	42,908	2,464	27,452	71,624
United States	262,779	39,240	19,766	39,503	169,743
Kenya	9,452	39,008	29,858	1,470	16,460
Canada	26,978	20,786	12,061	11,846	20,552
Sweden	28,043	17,530	764	43,795	15,702
Malaysia	10,322	15,165	10,935	19	10,838
Netherlands	28,452	12,347	967	8,922	14,664
Australia	5,022	6,353	1,771	4,787	1,822
Norway	-	5,402	567	2,960	-
Finland	-	3,574	12	251	-
Denmark	840	2,260	168	1,882	509
New Zealand	746	665	210	746	396
World totals	856,741	667,895	152,897	355,438	773,492

1.4 Asylum seekers in Australia

Few people seek asylum in Australia, both in absolute numbers and when compared against other countries throughout the world (see Table 1). In 2005, the number of new asylum claims in Australia represented only 0.95% of the total number of asylum seekers in the world. In the previous decade, when the number of asylum seekers in Australia has increased, this percentage has remained relatively stable: in 1998, the 8,156 asylum seekers who applied to Australia for the first time represented only 1.36% of the total number of new applications in the world (United Nations High Commissioner for Refugees, 1999).

It has been difficult to estimate the number of asylum seekers living in Australia at any one time. The Australian government has been reluctant to provide basic population information on asylum seekers in Australia, so numbers have been estimated from other sources of information. This issue has been noted in previous research regarding asylum seekers in Australia, particularly in relation to asylum seekers living in the community (Correa-Velez & Gifford, forthcoming; L. Harris, 2003; McNevin & Correa-Velez, 2006).

In February 2004, questions raised in the Senate Legal and Constitutional Legislation Committee went some way towards capturing this figure. At an Estimates meeting, the Department put forward that there were an estimated 8,000 individuals on Bridging Visa E in the community, a significant proportion of whom would be asylum seekers (Senate Legal and Constitutional Legislation Committee, 2004). The total number of persons in immigration detention as at 23 January 2004 was 997: of these, 300 had an application for protection in process or under review while 307 had a rejected protection application and review process completed affirming decision (Senate Legal and Constitutional Legislation Committee, 2004).

The combination of these figures, as well as the inclusion of those asylum seekers who would be living in Australia on other valid visas, would keep the estimated total of asylum seekers at around 8,000 in early 2004. This is a similar figure to the UNHCR's 2004 *Global Refugee Trends* which

estimates 9,215 asylum seekers had claims being processed in Australia in 2004 (United Nations High Commissioner for Refugees, 2005).

Since 1999, most research in Australia has estimated between 8,000 and 10,000 asylum seekers in Australia in any one year, depending on the method for estimation and the year of estimation (Amnesty International Australia, 2004; Harris & Telfer, 2001; McNevin & Correa-Velez, 2006; Melbourne Catholic Commission for Justice Development and Peace, 2004). There seems to be some discrepancy as to whether this is the figure for all asylum seekers or those living in the community, although the difference would be relatively minimal. No study has specifically included in this estimate those asylum seekers who have been taken from Australian waters to off-shore processing sites such as found in Nauru.

In April 2006, DIAC held a review of its bridging visa system. DIAC prepared an information sheet for community organisations and support agencies in preparation for its consultation (Department of Immigration and Multicultural Affairs, 2006a). This fact sheet does not have the DIAC insignia on it. This document states that around 2,700 persons on Bridging Visa E had an associated protection visa application, of which around 2,400 were seeking judicial review or Ministerial intervention. In addition, approximately 1,400 people were on a Bridging Visa A awaiting a primary or review decision on their protection visa application. This suggests the estimate for asylum seekers living in the community in Australia in 2006 is around 4,000 – 4,500 people.

1.5 The asylum process in Australia

The experience of seeking asylum in Australia can differ dramatically depending on two factors on arrival: whether the asylum seeker enters Australia with a valid visa as well as place and mode of arrival.

ARRIVING ON A VALID VISA

Many asylum seekers initially enter Australia on a valid visa (for instance, as a visitor) and then apply for a protection visa. These asylum seekers remain in the community while their application is processed. Once their original visa expires, they are placed on a 'bridging visa' until their application for a protection visa has been processed (discussed in section 4.3). Access to work rights, health care and basic support is severely restricted after a primary decision regarding their asylum claim has been made, or if they apply for refugee status after being in Australia for 45 days (Correa-Velez et al., 2005).

The proportion of visitor visa holders applying for protection visas after they arrived in Australia was 0.06% in 2004-05 (Department of Immigration and Multicultural Affairs and Indigenous Affairs, 2005).

ARRIVING WITHOUT A VALID VISA

A small number of asylum seekers arrive in Australia with no valid visa. The official term for these asylum seekers are 'unauthorised arrivals'. Asylum seekers who arrive in Australia's migration zone without a valid visa are given an initial 'compliance interview' by an immigration officer to establish whether they have legitimate protection claims. If they are deemed not to be legitimate asylum seekers at this interview, they are returned to their country of origin by the airline on which they arrived without being allowed to submit a formal application for a protection visa. This is called being 'screened out'. It is unknown how many people are 'screened out' through this process each year. Unauthorised arrivals are kept in immigration detention while their applications are processed (discussed further in section 4.2). There are a few circumstances, outlined in Regulation 2.20, in which asylum seekers can be released into the community while their application is processed, such as for minors with appropriate community detention arrangements, persons with special health requirements or for spouses of Australian residents. These circumstances do not require release into the community, but may allow for release into the community.

INTERCEPTION OUTSIDE THE AUSTRALIAN MIGRATION ZONE

Australia has excised most of the islands and waters north of the Australian mainland from its migration zone (Department of Immigration and Multicultural Affairs, 2006d). Persons who arrive in excised areas without a valid visa are taken to a 'declared safe country' where they are kept in an offshore processing centre. This is discussed further in section 4.4. Asylum seekers who arrive without a valid visa in such an excised offshore place are ineligible to apply for a visa in Australia. However, the Minister has the power to permit such people to make applications for visas of a specified class.

APPLICATION PROCESS⁵

An application for a protection visa is assessed, in the first instance, by a DIAC officer and given a primary decision. If a positive decision is made, then a permanent or temporary protection visa may be issued, depending on the circumstances of arrival: unauthorised arrivals are eligible for a temporary protection visa that allows residence for three years, while those who arrived with a valid visa are eligible for a permanent protection visa. If a negative decision is made, this may lead to either removal or appeal to the Refugee Review Tribunal (RRT). The RRT reviews the DIAC case file along with other information provided by the applicant. The RRT may affirm the primary decision, vary the decision, set aside the decision and submit a new decision, or remit the matter to DIAC for reconsideration. Specific issues regarding primary decisions and decisions from the RRT are discussed in Chapter 4. In some instances, an applicant may apply to the Federal court for review of judicial procedures. The application process is described in more detail in the Department's Fact Sheet 61 (Department of Immigration and Multicultural Affairs, 2006b).

After an asylum seeker has had a refusal at all levels of review, he or she may apply to the Minister to make use of his discretionary powers to intervene under S417 of the *Migration Act 1958*. A request for Ministerial intervention of itself will have no effect on the removal provisions of the *Migration Act*, although it is grounds for the granting of a bridging visa assuming the applicant meets the specified criteria for that visa. Consideration by the Minister for intervention is precipitated by either a request in writing by an asylum seeker or an asylum seeker's representative, or through automatic referral after a review authority rejects an application for review and affirms DIAC's decision on a protection visa application (Senate Legal and Constitutional References Committee, 2006). In 2004-2005 the Minister had 3,033 requests for intervention under s417, s454 and s501J, of which 142 were granted an intervention (Senate Legal and Constitutional References Committee, 2006). Ministerial intervention is discussed in more detail in section 4.8.

1.6 Seriously ill asylum seekers in Australia

There is no information published by the Australian government on the number of asylum seekers in Australia who are seriously ill. It is unlikely these data are readily available to the government, as DIAC are not necessarily aware of all of an applicant's health concerns, especially those that develop after an application has been lodged. In particular, mental health is not systematically assessed in health checks for visa applicants.

The impact of particular Australian policies on asylum seekers is a significant field of investigation, with research examining the impact of detention (Becker & Silove, 1993; Dudley, 2003; Sobhanian, Boyle, Bahr, & Fallo, 2006; Steel et al., 2006; Steel & Silove, 2001; Sultan & O'Sullivan, 2001), temporary protection visas (Barnes, 2003a; Mann, 2001; Mansouri, 2002; Marston, 2003; Momartin et al., 2006; Taylor, 2005a), and the bridging visa regime (Correa-Velez et al., 2005; Harris & Telfer,

⁵ This information should not be relied upon to undertake an asylum application. Please refer to the Department of Immigration and Citizenship for up-to-date information on applying for a visa.

2001; UQ Boilerhouse Community Engagement Centre, 2005). The impact of these policies has focused mainly on the deterioration of mental health status and as such is complemented by the more general body of research regarding the mental health of asylum seekers in Australia (Barnes, 2003b; Koutroulis, 2003; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; Sinnerbrink, Silove, Field, & Steel, 1997; Thomas & Lau, 2002).

DEFINITION OF SERIOUS ILLNESS

This research sought to investigate the impact of policy on asylum seekers with serious illnesses. For the purposes of the research, an illness is considered to be 'serious' if:

- (1) it requires specialised treatment (often over a long period of time); and
- (2) without appropriate medical treatment, it will cause the individual to lose the ability to lead an independent life (this would include, *inter alia*, illnesses that cause major disability, increased susceptibility to other illnesses, or premature death).

It is important to note that the definition of 'serious illness' as used for the research is intended to include both physical and mental illnesses, as both these areas of health impact on the wellbeing and quality of life of an individual, and can require use of treatment and support to continue daily living activities.

1.7 Refused asylum seekers in Australia

Asylum seekers who are found not to need Australia's protection, as outlined in the Refugee Convention, are subject to removal from Australia. Removal is the term used by the government for the "implementation of section 198 and the practices associated with the removal of unlawful non-citizens" (Senate Legal and Constitutional References Committee, 2006). This differs to deportation, which is the expulsion "of long term Australian residents convicted of a criminal offence" (Senate Legal and Constitutional References Committee, 2006).

Those awaiting removal may be in detention or in the community. In rare instances, individuals who have been waiting in detention for many years after being refused at all levels are released from detention on a Removal Pending Bridging Visa to allow them to live in the community while removal is arranged. This visa recognises that organising removal can sometimes be an incredibly difficult and long process, especially if the country of origin is unwilling or unable to provide travel documentation, or if it refuses to acknowledge the person as a citizen with legitimate claims to live in their country.

It is unclear how many asylum seekers are awaiting removal at any one time. As observed above, there is limited information on which to base estimates regarding asylum seekers in Australia. During 2005, 4,787 asylum claims were rejected in Australia (United Nations High Commissioner for Refugees, 2006). In 2004, 307 of the asylum seekers in detention had completed the application and review process, and consequently were in a position to be removed from Australia, but details for those in a similar position in the community are not available (Senate Legal and Constitutional References Committee, 2004).

1.8 Removing asylum seekers from Australia

There is a dearth of information available from the government on asylum seekers who have been removed from Australia. There is no reporting on the number of removees who were seriously ill at the time of their removal, or who required medical or welfare assistance during or immediately after their removal.

In 2004-05, there were a total number of 12,524 removals and departures of persons who had no authority to remain in Australia (Department of Immigration and Multicultural and Indigenous

Affairs, 2005). This includes people who have stayed longer than the time granted in their visa (overstayers), people who have breached a condition of their visa, people who arrived in Australia without authorisation and who did not engage Australia's protection obligations, illegal foreign fishers, visas cancelled or refused under s501 of the *Migration Act* (character related issues) and those whose visa was cancelled by the Minister. The vast majority of people with no authority to remain in Australia are overstayers, which at 30 June 2005 was estimated at 47,800 people (Department of Immigration and Multicultural and Indigenous Affairs, 2005).

1.9 Conclusion

This chapter has described the current international context of asylum populations and the countries that host them. Within the context of global asylum population movements, Australia is a small player. Australia hosts only a handful of asylum seekers yet has established a stringent asylum process that places significant limitations on asylum seekers' access to basic resources. This system has been established at the cost of the health and wellbeing of this small and vulnerable group of people. It is unclear how many asylum seekers are in Australia at any one time, and even less clear what proportion of that population is suffering from a serious illness. A lack of awareness of the health care status of asylum seekers living in Australia is perpetuated during the process of removal. This small population in Australia is experiencing significant levels of preventable mental and physical suffering and illness.

2. Methods

Qualitative research methods were used to undertake an investigation into the tensions between the right to health and current policies and practices in Australia regarding the removal of asylum seekers who are seriously ill. The themes elicited through in-depth interviews with thirteen service providers and one immediate family member provided a framework for integrating interview data and survey results. This was combined with evidence from the national and international literature.

2.1 Aims and objectives

This research was designed to document the practice of removing seriously ill asylum seekers from Australia within a broad international context. This section explains the methods used to achieve this aim. The specific objectives for the research were to:

- (i) Investigate Australian government policies and practices relating to the health care needs of refused asylum seekers who are seriously ill.
- (ii) Document the experiences of key community organisations that mediate cases of refused asylum seekers who are seriously ill.
- (iii) Describe the experiences of a small group of refused seriously ill asylum seekers.
- (iv) Compare policies and practices in Australia with relevant policies and practices of other ‘resettlement’ countries under the United Nations High Commissioner for Refugees (UNHCR) resettlement program.
- (v) Identify key areas of policy and practice that may be amenable to change which would in turn better protect the health and wellbeing of this group of asylum seekers.

2.2 Study design

This study made use of qualitative research methods to explore the policies and practices associated with the removal of seriously ill asylum seekers. A qualitative design provided a structure for exploratory research which allowed the removal policies particular to Australia to be seen within an international context. This methodology also allowed the researchers to investigate the experiences of seriously ill asylum seekers through detailed case studies, providing greater depth and insight into policy analysis. The research was approved by the Faculty of Health Sciences Human Ethics Committee, La Trobe University.

2.3 Literature review

Some of the issues that arise for countries responding to individuals who ask for protection have been addressed in the past by the international community through the development of human rights agreements. International human rights conventions and protocols provide some understanding of the responsibilities undertaken by Australia as a member of the global community. These conventions, and related literature regarding their interpretation and implementation, were used in this research to understand the removal of seriously ill rejected asylum seekers in the international context.

In addition, the policies and practices of Canada, Denmark, New Zealand, Sweden, the United Kingdom and the United States were used to understand the variety of interpretations and limitations placed on these agreements by nation-states when removing asylum seekers who are found not to need protection.

The policies and practices established by the Australian government and its Department of Immigration and Citizenship (DIAC) were used to understand the national legal framework in which removal occurs. Federal legislation and regulations in the area were considered primary policy documents and these were complemented by the official instructions provided to DIAC officers about policy implementation and practice, as found in their *Procedures Advice Manual* and *Migration Series Instructions*.

Previous research in Australia and overseas regarding the removal of asylum seekers, in the form of academic articles and books, contributed to a critical analysis of the competing obligations and practical dilemmas associated with removal. Reports by community based organisations and advocacy organisations who work with asylum seekers were also consulted. Some media reports were used to consolidate and question information regarding cases of removal from Australia. This was a particularly useful source for following the opinions proffered in public discussions regarding removal and health.

2.4 Interviews with case workers

Thirteen case workers from seven organisations working with asylum seekers were identified as key informants and interviewed about their experience working alongside seriously ill asylum seekers in Victoria. These community based organisations provide support through case work, health services, legal support, and counselling. The participants were professionals such as social workers, counsellors, lawyers and medical practitioners. Each interview lasted approximately 45 minutes using a semi-structured interview design. All interviews were recorded using a digital voice recorder.

These in-depth interviews provided information about removal from the point-of-view of those who work with asylum seekers through the entire asylum process, as well as at the initial stages of removal. These service providers brought to the research an encyclopaedic knowledge of the maze of policies and bureaucratic processes which come into play through the asylum process, as well as providing an insight into the ways in which those policies are experienced by the individuals and families who have sought asylum in Australia.

2.5 Survey of service providers

A short written survey was used to identify the type of health care needed by asylum seekers who were seriously ill and the barriers to accessing the care required. The survey also identified the number of seriously ill asylum seekers who had been removed in the previous two years, and the number who were awaiting removal. It also asked for an assessment of health care access and equity in Australia.

Community organisations around Australia that work with asylum seekers were identified for survey through a combination of nomination by key informants and independent identification by the researcher. Seventeen organisations were contacted by telephone and emailed a survey to complete and return. Three organisations chose not to complete the survey due to lack of experience with asylum seekers at the end of the asylum process. Nine completed surveys were returned by organisations in New South Wales (3), South Australia (1), Victoria (2) and Western Australia (3).

2.6 Issue of interviewing seriously ill asylum seekers

The original research design included interviews with approximately four seriously ill asylum seekers who were awaiting removal. Through the course of the research, a number of ethical and practical issues arose regarding these interviews.

ETHICAL ISSUES

Refused seriously ill asylum seekers have experienced political, social and personal disempowerment and are often physically and mentally exhausted from the demands of a serious illness that may be under-treated. Given this situation, the team discussed concerns that an interview focusing on health care and removal would have a deleterious effect on individuals who were in a highly vulnerable situation.

These concerns competed with our prior experience as researchers who had interviewed people living in a variety of highly precarious situations: asylum seekers returned to Iran, Pakistan and Afghanistan, asylum seekers living without support in the community, and individuals with terminal illnesses receiving palliative care. Our collective experience told us that people who had chosen to participate in an interview, even those in highly vulnerable situations, responded positively to the opportunity to tell the story of their experiences and give their opinion on matters that affected them so dramatically.

We were also aware that such conversations provide the only means to hear directly from those who have experience of a system at a personal level. It was decided to continue to try and include the voices of asylum seekers in the research through a small number of interviews.

PRACTICAL ISSUES

Case workers who identified potential participants were asked to discuss the research with their client at a time they felt was appropriate. They were aware that the care of their client was to be their primary concern: the research was not to be discussed with a client who had experienced a particular episode or set back in their illness(es), or who was not coping with the anxiety and emotional turmoil associated with their impending removal from Australia.

Given this mandate, case workers identified and attempted to approach four asylum seekers over the course of approximately six months. It is highly significant that none of the potential participants could be asked if they would like to participate in the research because their case workers found at each meeting or telephone conversation that their emotional and physical wellbeing was too fragile to raise the prospect of participation.

In one instance, an immediate family member of a seriously ill asylum seeker was asked to participate in an interview in place of their relative. This unstructured interview lasted about 1 hour.

2.7 Analysis

Literature gathered pertaining to international human rights legislation, health care access and removal was used to establish a clear context for understanding and analysing practices in Australia. This international context is presented in Chapters 3 and 5 through an analysis of the ways in which human rights agreements intersect at the point of removal for those who are seriously ill. The policies and practices found in other resettlement countries were similarly analysed for comparison with Australian practices.

All the interviews undertaken in the research were fully transcribed and analysed using a thematic analysis methodology (Hudelson, 1996; Rice & Ezzy, 1999; Tuckett, 2005). Systematic coding (Strauss & Corbin, 1990) was conducted to identify the key themes and issues presented by interviewees. Two researchers independently coded the first six interviews then met to discuss the themes arising from the data. A final theme list was consolidated after the remaining interviews had been coded. This theme list was then used to develop a framework to provide a structured relationship between the key themes and the variety of data pertaining to each theme.

The policies and practices documented by the Australian government through legislation and guidelines for officers have been synthesised into the analysis of the themes emanating from the interviews. Previous research and reports were also analysed and incorporated into the framework for key findings.

2.8 Limitations

The lack of voices from individuals who have experienced a serious illness while seeking asylum in Australia means the research lacks the insight of those most directly effected by the policies and practices under scrutiny. Future research in this area would benefit from a longer time period to conduct the research: this would allow the researchers time to establish relationships with individuals at an earlier stage of their claim for asylum when they are still able to consider participating in research. Such a relationship would allow the researcher to establish and continue a conversation around issues of health, wellbeing and asylum as the participant approaches removal.

The interviews with case workers has been limited to organisations working in Melbourne, Victoria and so not all results can be generalised to situations in other cities or to rural and regional areas. Melbourne has a number of organisations that are devoted to assisting asylum seekers, and this contrasts against the situation in most other parts of the country where asylum seekers rely on the assistance of charities that respond to a variety of people experiencing poverty and ill health in the community. This limitation also has implications for our understandings of the health care available to asylum seekers, as health care provision is delegated to the state governments. In particular, Victoria has recently been the first state to direct its public hospitals to provide health care to asylum seekers without charge (Department of Human Services, 2005). However, many of the experiences and difficulties of the asylum process in Australia are common across the states and territories, as the asylum process is mandated and coordinated by the federal government.

It should also be noted that the previous two years have led to enormous changes for both policies and practices relating to asylum seekers. A significant shift occurred after it was revealed in early 2005 that an Australian permanent resident named Cornelia Rau had been detained for 10 months in the belief she was an unlawful non-citizen. One issue contributing to her ongoing detention was the lack of care given to her mental health despite displaying multiple symptoms consistent with a mental illness (Palmer, 2005). An investigation into this issue revealed another significant case in which an Australian citizen had been detained and then deported to the Philippines on the presumption she was an unlawful non-citizen. Vivian Alvarez Solon was moved to detention from hospital after she had been treated for spinal injuries and brain damage as the result of a serious accident. Her confused mental state, lack of documentation and her use of her maiden name meant she was not identified correctly. She was eventually located in the Philippines and returned to Australia (Senate Foreign Affairs Defence and Trade References Committee, 2005b).

The revelation of these events has led to a variety of government inquiries into health care in detention, removal procedures and the workings of DIAC (Commonwealth Ombudsman, 2006b, 2006c, 2006d; Palmer, 2005; Senate Foreign Affairs Defence and Trade References Committee, 2005a, 2005b; Senate Legal and Constitutional References Committee, 2006). These inquiries have made numerous recommendations for change within DIAC. The Department has undertaken a process of renewal and change to address some of the issues that have been identified through these investigations. The changes that have already been introduced are identified where possible, but it should be noted that this report comes at a time of considerable flux: further changes are anticipated that will impact on some of the areas addressed by this research.

3. Asylum seekers, human rights and health

Human rights agreements call for nation states to recognise the rights of all humans within their borders, whether they are citizens or not. These rights include the right to seek asylum and the right to health. States are given greater responsibility for ensuring the most marginalised people within its population, such as asylum seekers, are afforded their rights. Australia's support for human rights must move beyond rhetoric and be effected in its policies regarding asylum seekers.

3.1 Introduction

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 1, Universal Declaration of Human Rights

The spirit and vision of our international human rights legislation is led by this courageous and revolutionary first article (Mann, 1998), in which the freedom and equality of all people is a birthright endowing a life of dignity and rights. This spirit of dignity is embodied through all the agreements which have consequently been developed to codify the rights of humans. The resulting body of international human rights law contributes to the ongoing task of protecting and promoting the dignity of all people.

Nation-states also enjoy rights associated with their sovereign power, such as the right to manage and regulate the entry and exit of non-citizens, and these rights can intersect, and at times compete with, the human rights of individuals within its borders. Negotiating the outcome in the conflict between state rights and human rights is a difficult task, but there is consensus that some international covenants impose obligations that override and limit state rights.

3.2 Human rights and non-citizens

Human rights legislation has been developed on the premise that all humans are equal, and as such states are responsible for the protection and implementation of rights for all persons within its borders. This is captured in the description of rights as 'human rights' rather than 'citizens' rights'. However, the rights framework relies on a nation state to protect and fulfil human rights, and in this conceptualisation, a state's responsibility for rights is sometimes limited to citizens. In this sense, there are ways in which citizenship continues to be seen as a prerequisite to the fulfilment of certain non-core rights. Conflicting interpretations of the rights of non-nationals have surfaced in debates surrounding the tension between states' rights and human rights, especially with regards to the rights of asylum seekers and refugees (Dent, 2003; Dwyer, 2004; Sengchanh, 2001).

3.3 The right to seek asylum

One limitation to state's rights is found in the right to seek asylum. Several agreements make it clear that people have the right to seek protection if they believe they are being persecuted. The right to

seek asylum is safeguarded in particular by the United Nations *Declaration of Human Rights*, which enshrines the right “to seek and to enjoy in other countries asylum from persecution” (United Nations, 1948).

Within the Refugee Convention, the right to seek asylum is less clearly articulated. However, two articles rely on the precept that individuals have such a right. Article 31 prevents Contracting States from penalising refugees on account of their illegal entry into their territory if they come directly from a territory where their life or freedom was threatened. This recognises that many people who need to escape persecution will not be in a position to organise valid travel documents and destination visas before their departure.

The right to seek asylum is also inherently protected by Article 33, which prohibits expulsion or return (*refoulement*) of a refugee “in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion”. Until it is absolutely clear that an asylum seeker will not face persecution on return, removal of someone claiming to be a refugee would transgress the intention of this clause.

3.4 Asylum seekers and the right to health

The right to health is outlined in a number of human rights documents, with the understanding that a state of health and wellbeing is indispensable for the fulfilment and enjoyment of all other human rights. The most comprehensive article on the right to health is found in Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR):

“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”

(Office of the United Nations High Commissioner for Human Rights, 1966).

Article 2 of the ICESCR makes it clear that this right should be applicable to everyone within a nation-state “without discrimination of any kind” (Office of the United Nations High Commissioner for Human Rights, 1966). In addition, General Comment 14 includes a specific instruction that health services must be “accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination” (Committee on Economic Social and Cultural Rights, 2000b).

The Committee also notes that the right to health is an inclusive right:

“... extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including sexual and reproductive health”

(Committee on Economic Social and Cultural Rights, 2000b).

This coincides with Article 25(1) of the Universal Declaration of Human Rights which states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...” (United Nations, 1948). The driving force behind these statements is that these rights are guaranteed for all humans regardless of their status in society.

There are several ways in which the Australian government fails to fulfil the right to health for

asylum seekers in Australia. Discrimination has meant that many asylum seekers do not have equal access to health care services. Asylum seekers with an illness cannot be assured of treatment, including access to medical staff, facilities and medication. Access to health care in emergency situations is not guaranteed but dependent on the policies of local states and territories. At certain stages of the application process, asylum seekers cannot rely on an adequate supply of food, water, basic sanitation or housing. The impact of this on the health of asylum seekers, and the implications for removal, are described in detail in Chapter 4.

3.5 Human rights and mental health

No human rights treaty has been developed to address the rights of individuals suffering from a mental illness. The international community has acknowledged the importance of mental health through the development of Principles for the Protection of Persons with Mental Illness, as well as with policy and services guidelines aimed at assisting countries to improve the mental health of their population (United Nations, 1991; World Health Organization, 1999, 2003). The principles and guidelines do not have the same force as human rights treaties, but make clear statements aimed at improving the dignity and treatment offered to those who suffer from a mental illness. It is recognised that some populations are more vulnerable to mental illness as a result of traumatic experiences, including displaced persons (including asylum seekers), people traumatized by conflict and war, and people living in extreme poverty (World Health Organization, 2003). A greater level of responsibility for these individuals is imposed on states to ensure that the rights of the most vulnerable members of society, such as asylum seekers and those who are mentally unwell, are not neglected.

3.6 Rights and removal

Nation-states have a right to remove individuals from their territories who have no legal basis for being present (Noll, 1999). For asylum seekers who have been properly assessed and are found not to need protection, removal marks the conclusion of the asylum process. Despite the difficulties encountered by nation-states in removing rejected asylum seekers, removal is considered an important tool in maintaining the validity of protection programs for recognised refugees (Gibney & Hansen, 2003).

The state's right to remove a rejected asylum seeker is limited when that person's human rights may be abused as a result of that action. Some responsibility is given to states who are removing non-nationals to ensure their rights will be secure upon return. The exact limits to this responsibility have never been clearly articulated in international law, and as a result states make their own assessment as to which rights they will protect in this manner.

Most states assume responsibility for protecting 'fundamental' rights but not others (Rohl, 2005). For example, many states will have some mechanism to ensure that a person is not returned to a country where they will be tortured. However, few states are willing to guarantee rights such as the right to health, unless these will be denied to the person for reasons outlined in the Refugee Convention. This issue is discussed in more detail in section 5.7.

3.7 Australia's support for human rights

Australia has been a strong supporter of human rights legislation at the international level, having ratified six major treaties and participated in the treaty processes including reporting procedures. This has also involved developing a National Framework and a National Plan for Human Rights in Australia (Commonwealth of Australia, 2004) and establishing the Human Rights and Equal Opportunity Commission to foster understanding and protection of human rights in Australia. However, these

administrative measures are only as effective as the practical steps taken towards their implementation, as noted by Australia's Minister for Foreign Affairs, The Hon. Alexander Downer MP:

The protection of human rights to promote the dignity of the individual is too important a matter for symbolic gestures alone. It is only through the pursuit of practical and effective efforts to promote human rights that we show our real commitment to the welfare of individuals and society (Department of Foreign Affairs and Trade, undated).

Although Australia has a history of supporting human rights legislation, there are some areas of policy and practice that have come under scrutiny at the international level. The process for reporting on the implementation of rights outlined in key treaties has highlighted some areas needing improvement. In particular, there is a call for improvement regarding the level of disadvantage experienced by indigenous Australians and the lack of federal legislation incorporating human rights instruments into national law (Committee on Economic Social and Cultural Rights, 2000a). Questions have been raised regarding the treatment of asylum seekers and refugees, with significant criticism regarding the use of mandatory and indefinite immigration detention (Committee on Economic Social and Cultural Rights, 2000c; United Nations Human Rights Committee, 2006).

4. Seeking asylum in Australia: Bad for your health?

Seeking asylum in Australia has a specific and tragic impact on the health of asylum seekers. Limits placed on access to health care and the basic resources needed for everyday life contribute to the deterioration of health status. Mental and physical health is also threatened by indefinite detention and by long periods spent waiting in uncertainty with little support and without opportunities for family reunion. Policies must be amended to ensure health is maintained throughout the asylum process. Responsibility must be taken for the future health of asylum seekers whose illness was instigated or cultivated as a result of their experiences in Australia.

4.1 Impact of seeking asylum in Australia on health

This research was designed to concentrate on the specific issues faced by seriously ill asylum seekers at the point of removal. However, the strongest finding emanating from the research was that removal is most affected by the process of seeking asylum in Australia and its impact on health and wellbeing. The results point to a variety of mental health issues which stem from the process of seeking asylum in Australia. Physical health can also deteriorate for some asylum seekers when they are left without treatment for significant periods when health care is not available to them. This strong association between ill health and the asylum process in Australia has significant implications when considering the practical and moral dilemmas associated with removal.

The evidence from the interviews, survey and literature review shows that asylum seekers' right to health is left largely unfulfilled during much of the asylum process in Australia. The ways in which Australia fails to fulfil this responsibility is multiple and varied: some policies and practices cultivate ill health; some policies and practices limit or prevent the treatment of ill health; and some policies fail to prevent ill health. This impact on health is particularly regrettable when the ensuing health issues cannot be treated in countries of return.

This section outlines specific aspects of the asylum process in Australia that have a significant impact on the health of asylum seekers and their families. Some aspects of seeking asylum – such as separation from family overseas and anxiety while waiting for an application outcome – will impact many asylum seekers around the world. The focus of this section of the report is on those policies and practices directly associated with seeking asylum in Australia.

The health impacts of the following aspects of seeking asylum are discussed:

- Detention
- Bridging Visa E
- Off-shore processing
- Screening out at airports
- Primary visa application decisions
- Refugee Review Tribunal
- S417 Ministerial discretionary powers

In each part of this section, we first outline the specific aspects of that area of the asylum process which most affect health. We then describe the kinds of impacts these have on health and the support

for that finding from existing research. The response by members of the public are outlined before recommendations for change are offered.

It should be noted that this list of factors which impact health is not comprehensive. Due to the limits of the scope of the research, we have necessarily focused on the most significant findings. However, each section provides references to other research or reports that provide further information. The Senate inquiry undertaken in late 2005 examines many of these issues in more detail (Senate Legal and Constitutional References Committee, 2006).

4.2 Detention

Australian legislation requires that asylum seekers who arrive in Australia’s migration zone without a valid visa, either by boat or by plane, must be kept in immigration detention indefinitely until their situation is resolved through the granting of a permanent, temporary or bridging visa, or by a negative visa outcome followed by removal. Asylum seekers are also placed in immigration detention if they have broken a condition of their visa while in the community or as the first step in the removal process (Department of Immigration and Citizenship, 2007). Immigration detention places great limits on detainees: movement is confined to within the centre’s grounds, communication and socialisation with others outside the centre is severely limited, and work and pleasure activities are highly restricted. DIAC has recently introduced measures that allow some detainees, such as families with children, to move into detention in the community. More detailed descriptions of the conditions of immigration detention can be found elsewhere (Human Rights and Equal Opportunity Commission, 2004).

IMPACT OF DETENTION ON HEALTH

There are several key aspects of detention which were seen by service providers to impact the health of asylum seekers, found in Table 4.1.

TABLE 4.1 IMPACT OF DETENTION ON HEALTH

Aspects of detention which impact health	Impact on health
• Length of time waiting in uncertainty in detention.	Contribution to the onset of mental health issues.
• Inadequate health care.	Deterioration of existing mental health issues.
• Separation of members of a family unit.	Exacerbation of existing physical illnesses.
• Management tools: <ul style="list-style-type: none">- Isolation unit.- Use of sedatives.- Treatment by staff.	Negative impact on the mental and physical health and development of children and minors.

LENGTH OF TIME WAITING IN UNCERTAINTY IN DETENTION

Service providers working with detainees argued that long term and indefinite detention is a significant factor in the onset and deterioration of mental health issues. Many cases were offered of detainees whose health had deteriorated in proportion to the length of time they had been held in detention.

This is consistent with existing research regarding the psychological implications of prolonged detention (Becker & Silove, 1993; Sultan & O’Sullivan, 2001). The detrimental impact of indefinite detention has also been a key finding in several reports regarding detention (Human Rights and Equal Opportunity Commission, 1998, 2001), with the most recent Senate Committee report concluding that “prolonged and indeterminate immigration detention is inherently harmful to psychological wellbeing and its abolition should be a priority” (Senate Legal and Constitutional References Committee, 2006, p. 204).

The UN Human Rights Committee has also concluded on five occasions that Australia’s use of prolonged detention is in breach of our human rights obligations under the ICCPR (Human Rights and Equal Opportunity Commission, 2006).

Despite the evidence regarding the impact of prolonged and indefinite detention, no legislation has been introduced to limit the length of time an individual may be kept in detention. As a result, asylum seekers continue to be detained indefinitely.

INADEQUATE HEALTH CARE

Service providers raised serious concerns about the quality and amount of health care available in detention centres. Some workers cited examples of clients who had sought health care for an affliction and had not been diagnosed properly, leading to inappropriate treatment and a deterioration in health (see, for example, Case Study 3). Others were concerned about the quality of treatment used for both physical and mental health issues.

In *S v Secretary, Department of Immigration & Multicultural & Indigenous Affairs*, two detainees brought an action against the Department in the Federal Court to allow their release to a hospital to obtain psychiatric care. In his concluding remarks, Finn J noted that the Commonwealth “continued to commit itself to treatment plans that may have been exacerbating, or else inadequately or inappropriately treating, the very conditions of the two applicants for which it was required to provide health care” (*S v Secretary Department of Immigration & Multicultural & Indigenous Affairs*, 2005). This has been reinforced by two subsequent government inquiries (Palmer, 2005; Senate Legal and Constitutional References Committee, 2006).

In response to the concerns highlighted in these inquiries, DIAC has now developed a Detention Health Strategy aimed at improving the health care delivered to detainees, relying on the advice of a newly established Detention Health Advisory Group (Department of Immigration and Citizenship, 2006b). Health care services are now separate from the detention management contracts, allowing for greater scrutiny and management. Agreements are also being made with relevant State or Territory health departments to clarify the roles and responsibilities of the different parties in overseeing health services in immigration detention. Service providers are hopeful these changes will lead to a significant improvement in the health of detained asylum seekers.

YOUNG MAN WITH SEVERE BURNS

Service Provider: *[A young man] was severely burnt in [detention]. Burns to all his body from the neck down, he had boiling water thrown over him ... There was some sort of a riot or something went on in the detention centre and I mean he's a lovely young man, the most gentle person you'd ever meet. So he had a really bad time. But eventually they transferred him from [one detention centre] to [another] and that's when I first met him ... He was in [that detention centre], God, it must have been nearly 2 years I spose. So there he was, you know, with those really bad burns never having the proper body suit or if he had a body suit, it should have been renewed a long time ago and it wasn't and I can remember seeing him, he'd have these, there'd be infections in his skin and the nurse used to just put Betadine on them. So he wasn't getting proper treatment at all. When he was finally released... the improvement in his skin after that was just amazing. I mean...you know when you've had something digging into your skin and all the little wounds are left in there, his skin on his arms is like that. But the improvement was unbelievable as the months went by, it's just amazing. Because he was getting proper treatment, he didn't have to beg for treatment. I mean, what I've seen in that place, its just terrible...I have seen it hundreds of times, of people who come out of detention and just the improvement in the short period of time.*

SEPARATION OF MEMBERS OF A FAMILY UNIT

The detention of children has caused considerable alarm among human rights advocates and the public alike. A government inquiry into the particular effect of detention on children has found that

children in immigration detention are at high risk of serious mental harm (Human Rights and Equal Opportunity Commission, 2004). As a result of pressure on the government regarding the impact of detention on minors, policies have been introduced to allow children and their families to be detained in residential detention in the community.

Although this is a significant improvement, service providers continue to be concerned about families who are separated during the asylum process and are critical of instances in which family members are detained in different locations. For those who are kept in detention, individuals in need of specialist care, such as women giving birth, can be separated from their family when they are taken to health facilities in another location (Hall, 2004). This can cause significant distress as they deal with a major health event without the support of family.

Research has shown that separation of family during the asylum process, for whatever reason, can have a significant impact on the health and wellbeing of all members of the family, and especially children (Rousseau, Mekki-Berrada, & Moreau, 2001; Sourander, 1998; Thomas & Lau, 2002).

Families continue to be kept apart through the use of detention and other processing structures in Australia. Despite some significant changes that have meant fewer children living in detention, there is no legislation preventing or limiting the detention of children, nor is there legislation ensuring that families remain together whenever possible.

WOMAN WITH CHILDREN TAKEN OUT OF DETENTION

Service Provider: *Now there's another ... woman, too, who had something similar happen, who had some young children. She was bereaved of everyone, I mean her whole family seemed to have disappeared or been killed. It's very sad. She's actually gone back to look for her husband after 10 years, she's got no leads, she's just flying there ... she was in detention for ages.*

Researcher: *With children?*

Service Provider: *Yeah. ... It was one of the most awful cases. She got really depressed and she started to believe the children hated her, that she's a bad mother and she deserved to die. The children were taken out of detention and she remained in for another nine months, six to nine months ... and then the children didn't want to come and visit her because they hated detention so they were scared to go back ...*

Researcher: *Who stayed with the family?*

Service Provider: *Oh, the kids stayed with her brother who was already a refugee who came here years ago. It was an awful thing, but he couldn't bring them in very often because he worked really long hours. So she eventually got a protection visa ... from the Minister. But that was ridiculous because God knows why she didn't just get that much earlier. The whole thing, she just went through these years of suffering unnecessarily. Because the situation (in her country of origin) hadn't changed in that period of time, so her claims were always very strong.*

MANAGEMENT TOOLS

Detention centres are run as extremely controlled and regulated environments and detainees are expected to adapt to the routines and regulations without causing any disruptions (Koutroulis, 2003). Many of the tools used to manage and modify the behaviour of detainees rely on persuasion or minor rewards. Some of the techniques used can be highly detrimental and have a major impact on health and wellbeing.

- ISOLATION UNIT

Some detainees are moved out of the communal areas into small rooms that contain only a mattress, toilet, shower facilities and a small window. They are kept there for an indefinite amount of time with little or no contact with others and extremely limited periods outside in recreational spaces. This process

is described as 'restrictive detention' by DIAC (Senate Legal and Constitutional References Committee, 2006).

The isolation and restriction of freedom imposed by this process can have a serious impact on mental health. Existing mental health issues can be compounded in such conditions, and new symptoms and issues may become established (Coffey, 2006). Physical health can be compromised when opportunities for exercise and movement are limited. These effects are confirmed in research relating to the use of isolation in prisons (Scharff Smith, 2004).

- USE OF SEDATIVES

Some interviewees were concerned that detainees were being given sedatives, or medication with strong sedating effects, to manage their behaviour on a regular basis. There are concerns that use of medication to control behaviour will impact both mental and physical health. This issue was noted by the recent Senate Committee inquiry, who called for greater independent investigation of the use of sedation for behaviour control in detention (Senate Legal and Constitutional References Committee, 2006).

- TREATMENT BY STAFF

There is concern about the attitude of staff towards asylum seekers and detainees. The detention environment emphasises security, and this is reflected in the culture of control established by many of the staff employed in detention centres (Sultan & O'Sullivan, 2001). In addition, many staff seem ill equipped to deal with detainees with serious mental health issues, and attempts to deal with behaviours stemming from these health issues often compound the causes of such problems. Cultural sensitivity has also been lacking, leading to a loss of dignity for detainees.

The detention environment can have a significant impact on individuals. The use of these management tools further compounds health issues, and in particular mental health issues, faced by detainees. DIAC have now established a College of Immigration to run training for its staff in a range of areas including compliance and detention management (Department of Immigration and Citizenship, 2006a). It is hoped this training college will provide an opportunity for DIAC to address these concerns with staff and develop a new approach to relating to asylum seekers in detention and the community.

RESPONSE OF COMMUNITY SECTOR

There has been a strong public lobby of the federal government attempting to end the use of mandatory and indefinite detention in Australia. Community responses aimed at alleviating the impact of detention on the health of individual detainees have included:

- Regularly visiting people in detention.
- Providing information and support to detainees.
- Assisting detainees in identifying health issues that have been neglected.
- Advocating for appropriate medical treatment.
- Advocating and supporting applications for the release of families and individuals into the community.
- Arranging and providing legal and migration advice.
- Arranging and providing post-detention counselling to individuals and families.
- Arranging and providing post-detention accommodation, material aid and support in the community.

RECOMMENDATIONS

To limit the impact of detention on the health of asylum seekers, we recommend:

- 4.2.1 Introducing an administrative or judicial review mechanism to ensure time limits on immigration detention are set.
- 4.2.2 Making greater use of bridging visas with connected entitlements to allow the release of identity, health and security cleared detainees into the community.
- 4.2.3 Increasing the quality and availability of health care in detention centres.
- 4.2.4 Introducing specific strategies to change staff attitudes towards detainees including training in managing individuals with serious mental health concerns.

4.3 Bridging visa conditions

Most asylum seekers arrive in Australia on a valid visa (such as a visitor's visa) and apply for protection after arrival. When their original visa expires, they are granted a bridging visa that allows them to remain in Australia legally until their application for a permanent visa is assessed. If they applied for a protection visa within 45 days of arrival, their bridging visa will usually allow them to work and to access Medicare the public health care system. These rights expire if they appeal beyond the Refugee Review Tribunal, such as applying to the Minister on humanitarian grounds.

If an asylum seeker applies for a protection visa after being in Australia for 45 days, their bridging visa will be issued with a stipulation of no right to work. This means that they are not allowed to work and, consequently, cannot access Medicare for the entire application process, with only a few exceptions. Some asylum seekers who have been detained on arrival may also be released into the community on a Bridging Visa E if they meet certain criteria. Anyone who has been a detainee is not eligible for work rights or Medicare access (Department of Immigration and Multicultural Affairs, 2005b).

If an asylum seeker is unable to meet their most basic needs, such as food, housing and health care, they may apply for income support from the government's Asylum Seeker Assistance Scheme (ASAS), operated by the Red Cross. This is available after six months has elapsed from the date of application or for those people who meet specific criteria. This support ends when an appeal to the Refugee Review Tribunal regarding their visa application is rejected.

Asylum seekers often struggle to meet their basic needs when they apply for protection in Australia, especially as they progress beyond the initial stages of the asylum process. Work rights, access to health care and income all become limited or unavailable at certain points, and individuals must find charitable strangers willing to support them to survive.

IMPACT OF BRIDGING VISA CONDITIONS ON HEALTH

The results from our research, shown in Table 4.2 below, highlight the ways in which certain bridging visa conditions impact the health and wellbeing of asylum seekers.

TABLE 4.2 IMPACT OF BRIDGING VISA CONDITIONS ON HEALTH

Aspects of bridging visas which impact health	Impact on health
<ul style="list-style-type: none"> • Limited access to Medicare restricts access to: <ul style="list-style-type: none"> - general practitioners - hospitals - specialist care - other health practitioners. • Limited access to medication and medical equipment. • Lack of work rights, income and housing. • Length of time waiting in uncertainty. • Lack of support and advice. 	<ul style="list-style-type: none"> Contribution to the onset of mental health issues. Deterioration of existing mental health issues. Exacerbation of existing physical illnesses. Negative impact on families including: <ul style="list-style-type: none"> - Higher levels of conflict due to high levels of stress and uncertainty. - Aggravation of situations involving domestic violence. - Demands of caring for a seriously ill family member without adequate medical and community support. - Minors caring for parents. - Minors acting as interpreters. Impact on mothers and newborns during pregnancy and childbearing.

LIMITED ACCESS TO MEDICARE

As described above, there are a number of points at which asylum seekers cannot access Medicare the national public health care system. This means that many asylum seekers lose their ability to access basic health services over long periods of time. In particular, the absence of the following specific services had the most notable effect on health:

- GENERAL PRACTITIONERS

Many asylum seekers find it difficult to access the basic health care services of a local general practitioner (GP). Without a Medicare card, and without money to pay for services, it can be extremely difficult to find a clinic or doctor willing to treat a patient for free. This can result in asylum seekers not seeking or receiving basic care for health issues that could be easily treated, or failing to have serious health issues diagnosed. This can lead to a deterioration in overall physical and mental health due to surviving illness without the assistance of treatment, as well as the cultivation and progression of specific illnesses due to lack of diagnosis and care. The lack of consistent preventative care provided by GPs, such as vaccinations, prenatal and maternal care, and sexual health care, also means health issues can become established.

Community groups have managed to set up a few small clinics to try and provide basic health care to asylum seekers with no Medicare access in some areas, but most of these clinics struggle to provide the care needed by their patients. A lack of resources and funding means such clinics rely on doctors and other health staff to volunteer their time and services. They also lack essential medical equipment and supplies and must try to negotiate free access to services that provide specific examinations such as x-rays, magnetic resonance imaging (MRI) scans, and pathology testing. When health staff provide such services for free, this can be done with significant personal risk for those involved due to insurance and risk liability.

- HOSPITALS

Although emergency health care is available to asylum seekers through the public hospital system, many asylum seekers have had difficulty in accessing this service when they are unable to show a Medicare card or evidence of private resources to pay for the services. In addition, many non-emergency issues need access to the expertise and equipment only available in hospitals. As a result, many asylum seekers have not been able to access the health care services provided by hospitals. As public hospital services are under the auspices of state governments, access for asylum seekers without Medicare or private funding varies from state to state. Some states, such as New South Wales, provide access to hospitals for asylum seekers who are receiving assistance through ASAS (Melbourne Catholic Commission for Justice Development and Peace, 2004). Within each state, some hospitals have been known to waive fees for asylum seekers who cannot access Medicare. Some hospital staff have also donated their time and skills to provide privately arranged services without cost. In December 2005, the Victorian government was the first state government to direct its hospitals to provide Medicare ineligible asylum seekers with full medical care including pathology, diagnostic, pharmaceutical and other services without charge (Department of Human Services, 2005).

The lack of access to hospitals has had an enormous impact on the health of asylum seekers. Serious health issues have been left untreated for long periods of time or have gone untreated altogether. Even when access to a hospital has been achieved, large bills have caused extreme distress and led to long and laborious advocacy efforts to try and get the bill written off. Hospital access has often relied on the efforts of doctors, social workers or other hospital staff who have been willing to make the effort to negotiate access without charge.

THE DIFFICULTIES IN ACCESSING GPs AND HOSPITALS

(Situation in Victoria prior to state government directive)

Service Provider: *People with access to Medicare obviously have the same access to medical care as anyone else in Australia. Then there are people without access to Medicare. The way that the system works in relation to people with no Medicare is very ad hoc at the moment and technically to go to any GP they will have to pay full fees for that service. They can go to the hospitals but we've had many situations where, even in an emergency, they've had to pay, or been demanded to pay a huge deposit like \$150, \$200 deposit before they'll be seen. That's not a regular thing but it has happened. It seems that some hospitals are more willing to see people in that situation. Some hospitals have developed protocols and made connections with agencies to provide support for asylum seekers and others haven't touched it with a barge pole...*

But it's so difficult. With some people, with people that have been seriously ill in hospital, we had one guy who actually passed away. He had cancer and it was kind of very sudden and he had to go to hospital and have an operation. He was in there for a very long time. Luckily the hospital was fantastic. It was still very difficult for the treating staff and the doctors to try and negotiate with the accounts department about what was going on and how to deal with the situation when the fees are incurring and of course this guy can't pay a thing.

So it's very stressful, I think, for clients, knowing that these fees are incurring, knowing that they might be forced to pay and not knowing how it's going to turn out.

I've had a client who's had a series of appointments at a hospital and then went for an operation. And she was kind of thinking it was all fine. When she went for the operation, they asked her for a Medicare card, she didn't have one, this is the morning before she's going into surgery, and it just caused this huge stress and a kind of kerfuffle within the hospital.

So it's the lack of systems, so even though I think it'll be fine, she was getting really worried thinking that she wouldn't be able to have the surgery and she'd have a huge debt to pay. We've had clients not go into emergency because they thought that they'd have to pay and that's the experience they've had, they're basing it on experience.

- SPECIALIST CARE

As with GPs and hospital access, asylum seekers without Medicare or private funding have found it extremely difficult to access the services of specialists such as, among others, surgeons, eye specialists and oncologists. As a result, serious health issues are often neglected and health conditions deteriorate. Some specialists have treated asylum seekers as private patients without charging them for their services. In Victoria, one person set up a network of medical professionals willing to provide specialist services to asylum seekers without charge. A specialist would assess the needs of asylum seekers referred to the network, then try to locate and organise the relevant specialists, space and equipment needed for treatment. This network is no longer required in Victoria.

- MENTAL HEALTH PROFESSIONALS

Asylum seekers can find it incredibly difficult to obtain mental health care when living in the community. This is largely because the costs associated with mental health services, such as seeing a psychiatrist or psychologist, can be prohibitive for those who have limited or no income. Mental health issues can deteriorate significantly without appropriate treatment and support. Community organisations that provide counselling for survivors of torture and trauma try to make their services accessible to asylum seekers through non-government funding sources.

- OTHER HEALTH PRACTITIONERS

Asylum seekers also need the support of a range of health practitioners such as optometrists,

physiotherapists and occupational therapists. These health practitioners also face the dilemma of trying to treat patients who do not fall within the scope of their funding parameters and who do not have the resources to pay for their services as a private patient. As a result, many asylum seekers have not been able to access health care from a range of practitioners who could provide treatment of ongoing health issues, assist with recuperation from health events such as surgery and illness, and promote the health needed for independent living.

Asylum seekers' access to health care has been identified as a key concern in a number of studies (Asylum Seeker Project Hotham Mission, 2003; Melbourne Catholic Commission for Justice Development and Peace, 2004; Silove, Steel, McGorry, & Drobny, 1999; Steel & Silove, 2001; UQ Boilerhouse Community Engagement Centre, 2005). It not only directly impacts health by limiting diagnoses, treatments and levels of care, but causes enormous levels of distress and anxiety. These policies create conditions in which the health of asylum seekers is compromised by lack of access to health care.

LIMITED ACCESS TO MEDICATION AND MEDICAL EQUIPMENT

Asylum seekers' access to health care is also compromised by their lack of access to medicine. Australia has a Pharmaceutical Benefits Scheme that ensures some medicines are available at reduced costs to people with low incomes. This scheme is only accessible for people with a Medicare card. Consequently, asylum seekers without access to the scheme must pay full price for any medicine.

This means many asylum seekers struggle to obtain the medicine they need for themselves and their children. This difficulty is compounded for those asylum seekers who are not allowed to work. Some illnesses subsequently develop well beyond the usual limits, and place an individual under great strain and at risk of damage or greater deterioration in the future. Other illnesses require regular and ongoing medication. Many asylum seekers released from long term detention into the community particularly struggle to maintain consistent access to pharmaceuticals prescribed to them while in detention (Asylum Seeker Project Hotham Mission, 2003).

LACK OF WORK RIGHTS, INCOME AND HOUSING

Asylum seekers living in the community can find themselves in a highly precarious situation: conditions attached to some bridging visas mean many asylum seekers living in the community are both barred from working and prohibited from accessing welfare support. They can be left isolated in the community with no funded support service. Levels of disadvantage and anxiety escalate once an asylum application has been refused by the RRT, as any existing working rights and welfare supports are removed. As a result, asylum seekers in the community can quickly become destitute once their sparse personal savings have been spent.

It can be difficult for asylum seekers to remain healthy under such circumstances. Their physical health can be compromised by the lack of food, housing, clothing, and basic hygiene items such as toiletries. Many asylum seekers become highly distressed when they are not allowed to work and provide for their families. Levels of anxiety and depression are also impacted by their inability to undertake productive activities such as working, studying or volunteering. Opportunities for relief through recreation are also minimal due to a lack of resources. The impact of lack of work rights and income has been documented in previous research regarding asylum seekers in Australia and elsewhere (Asylum Seeker Project Hotham Mission, 2003; Cholewinski, 1998; McNevin, 2005; Melbourne Catholic Commission for Justice Development and Peace, 2004; UQ Boilerhouse Community Engagement Centre, 2005). This is consistent with research demonstrating that post-displacement factors, including employment and material security, are associated with mental health outcomes among refugees (Porter & Haslam, 2005).

A recent decision by the House of Lords in the United Kingdom found that the removal of subsistence support from asylum seekers leading to destitution due to the lack of work rights amounted to inhuman or degrading treatment, thereby breaching Article 3 of the European Convention of Human Rights (*R v Secretary of State for the Home Department ex parte Adam*, 2005). Australian courts have not tested this definition, as an equivalent human right instrument has not been enacted in Australia.

LENGTH OF TIME WAITING IN UNCERTAINTY

The length of time somebody lives in Australia on a bridging visa depends on the amount of time it takes to process their visa application. Research conducted in 2003 among 111 asylum seeker cases found that 65% had been in Australia between 1 and 5 years and 30% had spent more than 6 years (Asylum Seeker Project Hotham Mission, 2003). Each stage of the decision-making process contributes to this issue. The longer somebody lives in Australia in uncertainty, the greater the impact the living conditions described above will have on their health. In addition, there is evidence that long periods living in a state of uncertainty can contribute to mental health issues such as depression and anxiety-related health issues (Rees, 2003; Steel & Silove, 2000). This risk is exacerbated, and the impact on mental health heightened, when an asylum seeker has previously experienced torture or trauma (Steel & Silove, 2001).

LACK OF SUPPORT AND ADVICE

Asylum seekers are faced with highly complex legal and bureaucratic processes to have their claims for protection assessed and to access any basic resources that may be available to them. Throughout this process, many asylum seekers are also dealing with high levels of fear as they wait for their claims to be assessed and while coping with the stresses associated with living in a new country. Some are also dealing with the impact of experiences of torture and/or trauma. Asylum seekers need basic support and advice to negotiate the difficult task of applying for asylum and accessing basic resources needed for day-to-day living. A comprehensive case management model would provide a key means to assist asylum seekers through the process. This would reduce the negative impact of seeking asylum on health and wellbeing (Mitchell & Kirsner, 2004). It would also contribute to a smoother process as asylum seekers would be assisted in fulfilling bureaucratic requirements and have a better understanding of the processes and protocols to which they must adhere.

RESPONSE OF COMMUNITY SECTOR

Health professionals and concerned private citizens have pooled resources and skills to try and find ways to ensure asylum seekers' access to health care in the community. As one case worker noted, the generosity of people in this regard provided "one really good part of the story". Community responses aimed at minimising the impact of bridging visa conditions on the health of asylum seekers included:

- Establishing free medical clinics.
- Arranging *pro bono* medical services from private practitioners.
- Providing medication and medical equipment.
- Advocating for those who are eligible for further ASAS payments.
- Advocating for a change in policy at the state, territory and federal levels.

RECOMMENDATIONS

To limit the impact of bridging visa conditions on the health of asylum seekers, we recommend:

- 4.3.1 Ensuring basic needs, including income, housing and health care, are met throughout the asylum process.
- 4.3.2 Ensuring work rights are available to asylum seekers throughout the entire asylum process.
- 4.3.3 Ensuring access to Medicare throughout the entire asylum process.
- 4.3.4 Limiting the time to process asylum claims at all stages.

4.4 Off-shore processing

Asylum seekers who arrive by boat in areas of Australian territory that have been excised from the migration zone are taken to an off-shore processing centre (Department of Immigration and Multicultural Affairs, 2005c). There are currently off-shore processing centres in Papua New Guinea (Manus Province) and Nauru. These centres are run by the International Organization for Migration. Any claims for protection are assessed by Australian authorities or by UNHCR. A review of a decision is available, although applicants cannot access the Refugee Review Tribunal or the Australian court system for this review. Australia does not undertake to grant an Australian visa for persons who are recognised as refugees through this process, but rather seeks to find a third country that will accept these refugees as residents. As a result, individuals and families may be kept in the centres indefinitely while a permanent solution is found. Although the large proportion of individuals in this situation have eventually been granted a visa for Australia, some individuals and families have also been resettled in New Zealand and Sweden.

Although off-shore processing centres are not considered by DIAC to be detention centres, many of the issues identified in onshore detention centres are also present in off-shore processing centres. Many of the issues discussed in section 4.2 regarding detention also apply to the off-shore detention facilities.

IMPACT OF OFF-SHORE PROCESSING ON HEALTH

The key areas of off-shore processing identified by service providers for their impact on the health of individuals are listed in Table 4.3.

TABLE 4.3 IMPACT OF OFF-SHORE PROCESSING ON HEALTH

Aspects of off-shore processing which impact health	Impact on health
• Detention in harsh conditions with limited health care.	Contribution to the onset of mental health issues.
• Limited access to application review processes.	Deterioration of existing mental health issues.
• Length of time waiting in uncertainty.	Exacerbation of existing physical health issues.
• Little access to legal assistance.	Negative impact on the mental and physical health and development of children and minors.

DETENTION IN HARSH CONDITIONS WITH LIMITED HEALTH CARE

Although off-shore processing centres are not described as detention centres by DIAC, there are considerable restrictions on personal freedom for asylum seekers living in these centres that have a negative impact on health and wellbeing. Although the Department has noted that, on Nauru, residents of the processing centres may move around the island during daylight hours (Department of Immigration and Multicultural Affairs, 2005c), this is provided that asylum seekers are accompanied outside of the centres by officers who monitor movement beyond the centre's periphery (Penovic, Dastyari, & Taylor, 2006; Senate Legal and Constitutional Legislation Committee, 2006). This lack of personal freedom would have a similar impact on health and wellbeing as for those people detained in immigration detention centres in Australia.

The facilities and health care provided to residents of offshore processing centres can contribute to the deleterious impact of offshore processing on the mental and physical health of asylum seekers. The International Organization for Migration is charged with the task of running the centres and providing for the health and welfare needs of its residents. The remoteness of the island makes ongoing health care difficult to achieve on site, resulting in the transfer of a number of residents to Australia for specialist treatment.

Given that Nauru is a remote and tiny Pacific island that lacks an adequate fresh water supply, supply of fresh food and reliable energy, these conditions would necessarily impact on the living conditions of residents of these processing centres. The lack of doctors available in Nauru for its own residents means that local medical assistance is inadequate or unreliable (Gibson, 2006).

LIMITED ACCESS TO REVIEW PROCESS

Asylum seekers who are processed through offshore systems do not have access to the legal and merits reviews that are available to onshore asylum seekers. This discrepancy reduces the strength of decisions made regarding refugee status by limiting the independent review process. This is particularly disturbing given that the Refugee Review Tribunal has set aside or remitted 2730 cases in past the three financial years, with an average of 30% of cases being set aside for the 2005-2006 period (Migration Review Tribunal and Refugee Review Tribunal, 2006). This disturbing statistic means that one-third of decisions made at the primary stage are not consistent with the Refugee Convention, a poor indictment of the reliability of the Department's decision makers.

This review process is not accessible for asylum seekers who are processed offshore. Instead, a review may be undertaken by the same organisation that made the primary decision. Given that the Department of Immigration and Citizenship is one of the institutions making primary decisions for offshore applicants, their track record shows there is a need for independent review to ensure protection needs are adequately assessed. The removal of people who are in need of protection is unconscionable and will result in serious impacts on mental and physical health and wellbeing.

LENGTH OF TIME WAITING IN UNCERTAINTY

There is much descriptive evidence that the mental health of asylum seekers who have been held in off-shore processing centres has deteriorated through the period of detention to unacceptable levels of ill health. The services provided in these situations have been ineffective at alleviating the symptoms of distress and illness that have been evident in long term residents. A former psychiatrist at the processing centres on Nauru documented the disturbing rates of mental health problems amongst the residents of the centres in late 2002: while one in ten male residents attended his services after seven months residence, this proportion escalated to one in four residents for those who had been there almost a year (Fowler, 2003). He reported his concerns to the management in the following terms:

"I seldom or never encounter an asylum seeker who still sleeps soundly and is able to enjoy life. Mental health, or psychiatry for that matter, is basically not equipped to improve their situation in any essential respect" (M. Dormaar in Fowler, 2003).

By October 2005, 25 of the 27 men who continued to be held on Nauru were granted visas for Australia after mental health experts warned that they were at an extreme risk of committing suicide after four years in offshore processing centres (Gordon, 2006). The Nauruan government has been concerned about the length of time it has taken to resolve the cases of some asylum seekers due to the impact it has had on mental health (Kirk, 2006). This descriptive evidence is supported by the evidence regarding the impact of onshore detention on mental health described in section 4.2.

LIMITED ACCESS TO LEGAL ASSISTANCE

It is difficult for asylum seekers who are processed through offshore facilities to obtain legal advice. Australian lawyers who have previously attempted to travel to Nauru in order to meet with clients have, on numerous occasions, been unable to obtain a visa to enter the island (Senate Legal and Constitutional Legislation Committee, 2006). Legal advice has been given over the telephone and by mail, hindering accurate and timely representation. This issue will have a significant impact on the ability of asylum seekers to make accurate applications for protection that provide the appropriate information needed to undertake assessment. Without assistance in understanding the application process, asylum seekers will not intuitively know which aspects of their life story are most salient to the Refugee Convention definition. In addition, many will be undertaking this application in English without the level of translation needed.

The practical limits placed on obtaining legal advice and assistance means that asylum seekers who are processed in offshore centres may not have their protection needs accurately assessed. This can have devastating effects for their health and wellbeing should *refoulement* occur.

RESPONSE OF COMMUNITY SECTOR

Concerned members of the community have attempted to limit the impact of off-shore processing on asylum seekers and their health by:

- Maintaining contact with asylum seekers in off-shore processing centres.
- Advocating for the release of families with children from off-shore processing centres.
- Arranging and providing legal and migration advice.
- Advocating for proper treatment of health issues.
- Counselling for individuals and families after arrival in Australia.

RECOMMENDATIONS

To decrease the impact of off-shore processing on the health and wellbeing of asylum seekers, we recommend:

- 4.4.1 Ending the use of off-shore processing by recognising all of Australia as part of the migration zone and processing all asylum claims onshore.

Notwithstanding recommendation 4.4.1, we also recommend:

- 4.4.2 Introducing an administrative or judicial review mechanism to ensure time limits on off-shore detention are set.
- 4.4.3 Making greater use of bridging visas with connected entitlements to allow the release of off-shore detainees into the Australian community for health reasons.
- 4.4.4 Increasing the quality and availability of health care in off-shore processing centres.
- 4.4.5 Ensuring supported access to legal advice.
- 4.4.6 Ensuring asylum seekers found to be refugees are offered permanent protection in Australia.

4.5 'Screening out' and 'expedited removals'

Asylum seekers who arrive by air at Australian airports do not always successfully clear immigration control. If an arrival does not clear immigration control, they are interviewed by a compliance officer in a 'compliance interview'. In this interview, an asylum seeker must state their refugee claims clearly in order to engage Australia's protection obligations and be allowed to submit a full protection application. The claims presented in this interview are considered by a DIAC officer who decides whether the claims are credible and fall within the scope of assessment of the Refugee Convention. This officer will ask questions that may elicit information from the individual, but they will not prompt the asylum seeker to clarify their status, such as asking whether they have come to Australia to seek asylum, or whether they are a refugee (Mares, 2001). All individuals who do not clear immigration are considered to be unlawful arrivals and can be removed from Australia within 72 hours, preferably by the same carrier that brought them to Australia (Senate Legal and Constitutional References Committee, 2000). This process is variously termed 'screening out', 'turnarounds' and 'expedited removals'.

A similar process befalls asylum seekers who arrive by boat without a valid visa. In their compliance interview with a DIAC officer, they must articulate their claims to be a refugee or asylum seeker and/or their fears of returning to their country of origin for one of the reasons outlined in the Refugee Convention. Without invoking refugee terminology, and the rights to an assessment systems it provides, asylum seekers will face immediate removal or indefinite detention while a solution is found. The discrepancy between treatment of those who have successfully invoked Australia's obligations to

assess refugee status and those who have not invoked that right led to high levels of tensions and frustrations among boat arrivals being held at Woomera detention centre (Mares, 2001).

It is not possible to know how many persons removed in these circumstances may have been legitimate asylum seekers or refugees, or who made refugee-like claims during their interview. There were a total of 1,632 people who were refused immigration clearance at Australian airports in 2004-05 (Department of Immigration and Multicultural and Indigenous Affairs, 2005).

IMPACT OF SCREENING OUT AT AIRPORTS ON HEALTH

The impact of the screening out process on the health of asylum seekers is listed in Table 4.4 below.

TABLE 4.4 IMPACT OF SCREENING OUT PROCESS ON HEALTH

Aspects of screening out which impact health	Impact on health
• Protection needs may be inadequately assessed.	Removal to a country where health is at risk due to persecution.
• Legal advice is not accessible.	Removal to a country where health is at risk due to human rights abuses.
	Removal to a country where health is at risk due to lack of health services and treatment.

PROTECTION NEEDS MAY BE INADEQUATELY ASSESSED

There is concern that the protection needs of asylum seekers may not be adequately recognised in the compliance interview used in the screening process. This may lead to the *refoulement* of a person or persons who require protection. This issue was noted in 2000 Senate Committee report *A Sanctuary Under Review* (Senate Legal and Constitutional References Committee, 2000). A number of witnesses outlined their concerns about the reliability of this process in identifying refugees. These concerns focused particularly on the onus placed on asylum seekers to adequately articulate their refugee claims while in a confronting and difficult situation. Asylum seekers in this situation may be incredibly distrustful of people in positions of authority and may find it difficult to reveal details of personal experiences of persecution while disoriented, hungry, scared, and without representation. While acknowledging the possibility that persons may be turned around without sufficient consideration of their situation, the Senate Committee also reported that a random sample, by UNHCR, of approximately half the interviews conducted in the first half of 1999 revealed no evidence of any violation of Australia’s *non-refoulement* obligations under the Refugee Convention (Senate Legal and Constitutional References Committee, 2000).

However, these concerns were validated in part by reports of five asylum seekers who had been determined not to be refugees through this process but who, through external intervention, were permitted to submit full applications. All five were subsequently found to be refugees when assessed by the standard application process (Senate Legal and Constitutional References Committee, 2000; Steel & Silove, 2001). DIAC must be vigilante that the screening process actively identifies asylum seekers to ensure that it does not place refugees at risk of removal to places in which they will experience persecution.

LEGAL ADVICE IS NOT ACCESSIBLE

One of the criticisms of the screening out process is that it does not provide legal advice for persons who are taking part in a compliance interview. Most asylum seekers would not be aware of their right to obtain legal advice in this situation and consequently attend the interview without any support or advice. This means they are less likely to be aware of those aspects of their experience prior to arrival that may provide evidence of their need for protection. As the assessment of refugee status relies heavily on fulfilling certain criteria, legal advice would support an asylum seeker in identifying the most relevant aspects of their own experience.

RESPONSE OF COMMUNITY SECTOR

There are few opportunities for the community sector to support asylum seekers who go through the screening process, but these have included:

- Advocacy for arrivals being screened out at airports.
- Arranging and providing legal and migration advice when able.

RECOMMENDATIONS

To reduce the possibility of the screening process leading to *refoulement*, we recommend:

- 4.5.1 Increasing the transparency and accountability of the airport arrival screening process.
- 4.5.2 Promoting the use of a legal advisor during compliance interviews.

4.6 Primary decisions

A protection application to the Department of Immigration and Citizenship is assessed at the first instance through a primary decision, made by a DIAC case officer. This provides the key decision on an application for protection: a positive decision will lead to the granting of a visa, while a negative decision will lead to removal unless the decision is appealed by application to the Refugee Review Tribunal (RRT). Service providers were concerned about a number of aspects of primary decisions that impacted on the health of their clients and the consequences for removal. As one service provider noted, the “process breaks down when you don’t trust the assessment process.”

IMPACT OF PRIMARY DECISIONS ON HEALTH

The impact of primary decisions on the health of asylum seekers is listed in Table 4.5 below.

TABLE 4.5 IMPACT OF PRIMARY DECISIONS ON HEALTH

Aspects of primary decisions which impact health	Impact on health
• Primary decisions which lack integrity and consistency.	Contribution to the onset of mental health issues.
• Length of time waiting in uncertainty for primary decision to be made.	Deterioration of mental health issues. Negative impact on families including higher levels of conflict due to stress and uncertainty.
• Interview process and other contact with DIAC staff, including disbelief and lack of respect for applicants’ traumatic experiences.	Health at risk if <i>refoulement</i> occurs. Decision to provide a permanent visa leads to positive impact with the end of uncertainty and full treatment of health issues.
• Processing errors.	Decision to provide a temporary visa leads to limited positive impact by providing access to health care but continuing the negative impact of uncertainty and lack of family reunion.

DECISIONS LACK INTEGRITY AND CONSISTENCY

Many service providers were concerned by the perceived lack of integrity and consistency in DIAC primary decisions. These concerns arose from service providers noticing negative decisions for strong cases; inconsistency of results for cases with similar circumstances; and the high level of RRT set aside rates. Service providers’ greatest concern was the lack of protection for those asylum seekers whom they felt were clearly refugees. From their experiences working with clients, many service providers felt that the primary decisions regarding protection needs could be inaccurate. This was fuelled by a difference in assessment of the situation in the country of origin: Case Study 2 shows the situation of a woman who was told that she would be safe if she returned to a different area of her country of origin, a claim which was disputed by many who felt this was an inaccurate assessment of her level of safety from persecution on return. Service providers spoke of clients who had strong protection claims and yet received a negative primary decision. Assessments such as these presented a flawed system that was unable to identify those most in need of protection, with serious and disturbing results for applicants.

Concerns regarding primary decisions were also raised due to differing primary decisions for

separate applicants with extremely similar circumstances. Some service providers were aware of members of the same family receiving different decisions despite having extremely similar experiences as a family. Service providers were concerned that decisions might be heavily reliant on the case officer who was assessing the file. This discrepancy created unequal recognition of refugee status for applicants.

Service providers felt their concerns regarding primary decisions were evidenced, to an extent, by the number of applications that were set aside by the RRT. According to their 2005-2006 annual report, the RRT set aside 30% of cases it reviewed, suggesting that one-third of the negative decisions made by primary decision makers were inaccurate. This was of particular concern regarding the set aside rate for Iraq (97%) and Afghanistan (94%): almost every negative decision was referred back to the case officer for reconsideration. The set aside rates for both Nepal (31%) and Sri Lanka (30%) indicated primary decision makers also had a poor understanding of protection risks in these countries.

The reliability of primary decisions has been called into question by the two most recent Senate Committee inquiries into DIAC's operations (Senate Legal and Constitutional References Committee, 2000, 2006). Each of these committee reports provided recommendations that would create stronger, more reliable primary decisions. The current system lacks confidence from service providers and applicants alike. Improvements are needed to ensure that the assessment process recognises those in need of protection. A strong and consistent assessment system will establish greater confidence in decisions and lead to support for removal outcomes.

FINDING A BETTER WAY OF DOING IT

Service provider: When you get fairly close to them, you kind of know the ones who have stronger claims to being fearful of persecution and those who aren't. I mean it doesn't take you long, really, to work that out. You can be reasonably confident. But the people who get accepted and those who don't, are not necessarily, don't necessarily correlate with what you've learnt. And you think 'Ooh, there must be some better way of doing it.'

LENGTH OF TIME WAITING IN UNCERTAINTY

As discussed in previous sections, service providers are concerned at the impact of long periods uncertainty on the health and wellbeing of asylum seeker clients. Service providers felt that it took too long for primary decisions to be made, and this had ramifications for the health of their clients. The impact of long periods of waiting has previously been identified as a factor which increases risk of retraumatisation (Silove, McIntosh, & Becker, 1993). This issue has been described in detail in sections 4.2 and 4.3.

In 2006 (after the interviews with service providers were completed) DIAC introduced a 90 day time limit on processing applications at the primary stage. This is a welcome change that may go a long way to reducing the impact of uncertainty on the health of asylum seekers in Australia. However, this is only an improvement if the time limits placed on processing do not devalue the quality of decisions being made. DIAC has, in the past, been criticised for emphasising the speed of primary decisions over the quality and accuracy of the assessments made, with the criticism that this has resulted in more work for RRT and greater costs overall for government (Senate Legal and Constitutional References Committee, 2000). DIAC must ensure it has the resources and staff in place to meet a 90 day time limit without compromising the integrity of its decisions.

CONTACT WITH DIAC INCLUDING INTERVIEWS

Asylum seekers had inconsistent interaction from DIAC officers, from no contact at all through to contact from multiple officers. Service providers reported that their clients were keenly aware of the nature of interactions with DIAC staff, and pointed to the impact this had on asylum seekers' perception of the asylum system. This was particularly evident for asylum seekers who felt that their

claims were not believed, who found staff aggressive or dismissive, and whose traumatic experiences were swept aside as unimportant to their refugee claim. There have been significant improvements in this area in recent times.

These issues were more pronounced in formal interviews with DIAC officers. There were concerns that the adversarial approach used when questioning applicants causes high levels of distress for asylum seekers who have previously been traumatised as a result of interrogation sessions. This approach by DIAC staff displayed a lack of understanding of the impact of the refugee experience on applicants. DIAC staff should be encouraged to take on a culture of objective compassion and respect towards all applicants. Staff undertaking interviews could display more concern for an applicant's situation and previous experiences without forfeiting objectivity. This may include allowing applicants to describe experiences that do not fall within the purview of the definition of a refugee. This would ensure applicants feel that their whole story has been heard and assessed by the government, and give more confidence in the final decision.

IMPACT ON MENTAL HEALTH OF NOT BEING BELIEVED

Service provider: For example, there's ...a fella who was an academic in his own country. Vague, as the stereotype of the academic is. He lost some money and documents on his way out to a conference. He hadn't been here long when he heard that ..., on the basis of something that he'd written, he was being accused of blasphemy by the Islamic authorities ...He concluded he would be put in jail if he turned up and went home, so he asked for asylum here. He's got two little children at home.... He's just a person of huge integrity. He'd sort of been suffering but the final blow came when the Department official who heard his case ...decided he wasn't going to be given refuge ...because they didn't believe what he'd told them. Now that was a far bigger thing for him even than being told he wasn't going to be accepted. It was he wasn't going to be accepted on the basis that he'd told lies. And I mean, he's just a person of huge integrity so the depression came over him then. I mean he'd been in a sort of a state before, but being able to [work]...He was allowed to work because he'd asked for asylum within the 45 days, etc and he was really very scared all the time but he'd keep taking the next step. You know we got him to get a taxi licence and he's driving a taxi. ... But I'm bringing him up because I think he's typical of when they're not believed, you know. Now, some spin a yarn. You know, I'm not whitewashing all people who apply for protection because I know. I know some just tell stories. But many don't. And for those who don't and who then are not believed, it's a very big blow. I think that's one of the main things about mental illness. And the other one is the sheer uncertainty of it all. We find that all the time.

PROCESSING ERRORS

Service providers were concerned at the number of bureaucratic errors made by DIAC which impacted their clients. These errors were administrative errors that did not impact the decision on a visa application, but that nonetheless caused a large amount of distress for their clients. This included instances in which the applications of a husband and wife were not separated after notification of divorce; children not being listed on applications; and miscommunication about requirements or instructions. Service providers were aware that clients found communication with DIAC incredibly stressful and this was compounded when they had to sort out problems with their application or misinformation. It is important that DIAC staff manage applications with as few errors as possible to ensure smooth processing of claims.

IMPACT OF ADMINISTRATIVE ERRORS

Service provider: *The family I am thinking of have been in the community all the time, but ... there's been a family breakdown in the situation so the mother and the father have separated and separated their cases, where the mother has tried to separate her case, a lot of domestic violence and Immigration have consistently mucked it up so it hadn't been separated on their system so that every time the husband would have a decision, that has been relayed to the wife and children so that they've been spiralling out of control. They've been threatened with detention. Just last week Immigration turned up at their house wanting to detain them because the husband had become illegal and it was on the system that she was in the same situation.*

RESPONSE OF COMMUNITY SECTOR

In response to the impact of primary decisions on clients, workers from the community sector have aimed to minimise impact on asylum seekers by:

- Arranging and providing legal and migration advice.
- Advocating for specific cases.
- Lobbying for more consistent and reliable decision making.
- Providing moral and emotional support.

RECOMMENDATIONS

In order to improve decisions at the primary level, we recommend:

- 4.6.1 Strengthening the quality, integrity and consistency of primary decisions.
- 4.6.2 Training officials on the effects of the refugee experience on individuals.
- 4.6.3 Establishing a consistent DIAC staff culture of objective compassion and respect, and ensuring sensitive interactions with clients.

4.7 Refugee Review Tribunal

The Refugee Review Tribunal (RRT) is an independent merits review tribunal. If an application for a protection visa is refused at the primary level, it may be reviewed by application to the RRT. A member of the Tribunal reviews cases based on the DIAC case file and any other information provided by the applicant. In most cases, applicants are asked to attend a hearing with the Tribunal member to answer questions and provide further information. The RRT has the power to affirm the primary decision, vary the decision, set aside the decision and submit a new decision, or remit the matter to DIAC for reconsideration.

Service providers felt that primary decisions should be reviewable by an independent body to ensure that cases are assessed accurately. Many felt this was confirmed by the high rates of cases being set aside by the RRT (discussed in section 4.6).

IMPACT OF REFUGEE REVIEW TRIBUNAL PROCESS ON HEALTH

Service providers felt there were some aspects of the review process that could change to decrease the impact on the mental health of asylum seeker clients. These are outlined in Table 4.6.

TABLE 4.6 IMPACT OF REFUGEE REVIEW TRIBUNAL ON HEALTH

Aspects of Refugee Review Tribunal process which impact health	Impact on health
• Dismissal of credible evidence.	Contribution to the onset of mental health issues.
• Interview process, including limited consideration of traumatic experiences.	Deterioration of mental health issues.
• Inadequate assessments of situation in countries of origin.	Negative impact on families including higher levels of conflict due to high levels of stress and uncertainty.
• Length of time waiting in uncertainty for a Tribunal decision to be made.	

DISMISSAL OF CREDIBLE EVIDENCE

Service providers were concerned that RRT members did not give appropriate consideration to important evidence regarding an asylum seeker's claims. Of particular concern was the lack of weight given to evidence provided in reports by medical or psychological specialists. The reports provided by medical and psychological experts usually explain the ways in which an asylum seeker's medical condition may be consistent with their claims of torture and persecution (for instance, if there is scarring on the body that is consistent with claims of certain instances of torture). These reports were treated in an inconsistent and arbitrary manner. This concerned service providers, who felt that these assessments provided significant evidence regarding the consistency between a person's claims and their medical situation.

Service providers were also concerned that RRT members seemed unaware of the ways trauma and distress can impact on an asylum seeker's ability to recall and communicate traumatic experiences. This impact can mean that an asylum seeker's evidence may have minor inconsistencies that are consequently used to make adverse conclusions regarding the applicant's credibility. While recognising the difficult task set before RRT members in assessing applications, service providers felt that such assessments of credibility put some asylum seekers at risk of *refoulement*. Concerns regarding the Tribunal's use of credibility evidence has been noted in other forums (Coffey, 2003; Senate Legal and Constitutional References Committee, 2006).

In response to these concerns, and particularly to Recommendation 25 from the Senate Committee report (Senate Legal and Constitutional References Committee, 2006), the RRT introduced credibility guidelines in October 2006. This document provides Tribunal members with clear instructions regarding the assessment of an applicant's credibility and covers areas such as 'Tribunal hearings', 'Oral evidence' and 'Expert evidence'. This document should be a great resource to Tribunal members, and it is hoped that many of the issues outlined above will be alleviated as a result of its implementation.

LACK OF WEIGHT GIVEN TO EVIDENCE FROM MEDICAL EXPERTS

Service provider: a systematic and routine form of behaviour by bureaucrats and decision makers at both the Department and Tribunal level is to effectively ignore or discredit medical evidence or psychological assessments One of the real problems with doing that is that it almost always lacks a basis... If the system worked properly then a very strong regard would be had to that sort of evidence and ... there would be a presumption that ... being unwell might be completely consistent with the assessment... of the central question of refugee status... [O]ne of the well-established legal tests assessing refugee status is, if the person has in the past suffered human rights abuse from the same persecutors that they fear, that ought to be considered to be a powerful indicator of the possibility of future risk. So you can see how central someone's illness might be to an actual assessment about what their protection needs are and yet the system has fundamentally failed in that regard in my view.

INTERVIEW PROCESS

Some service providers were concerned about the impact of RRT hearings on their clients, especially those who were seriously ill or in the late stages of pregnancy. The RRT conduct hearings with most applicants as part of the review process. These hearings give the Tribunal member an opportunity to ask questions of the applicant to clarify any information being considered, give the applicant an opportunity to present their case, and allow the Tribunal to hear evidence from independent witnesses. Service providers were concerned that some applicants find these hearings to be highly stressful. For this vulnerable population, this level of distress can have significant impacts on health. There is a particular risk for applicants who have been interrogated in more malicious circumstances in the past. An applicant is required to remain cohesive when recalling traumatic situations from their past, and the hearing setting may affect an applicant's ability to do this with a clear mind. This effect may contribute to adverse conclusions regarding the applicant's credibility. This issue was raised in a previous Senate Inquiry (Senate Legal and Constitutional References Committee, 2000), which recommended that "further training be provided for RRT members in the use of those inquisitorial methods accepted as integral to the Tribunal" (p. 151).

These issues need to be addressed by the RRT to ensure that the impact of hearings on applicants is minimised. The timing of the interview, the demeanour of the Tribunal member and the setting can all be managed to ensure that applicants go through the least amount of distress during the review process, and reduce the impact of emotional distress on the presentation of evidence during the hearing itself.

INADEQUATE ASSESSMENT OF SITUATION IN COUNTRY OF ORIGIN

The RRT uses information regarding the country of origin in its determination of refugee status. This information can be obtained from several sources, including from the RRT Country Research team. Service providers were concerned that the conclusions made by RRT members regarding risks of persecution in countries of origin conflicted with assessments of these risks made by other organisations, such as non-government organisations, international monitoring bodies, and asylum seekers who were in contact with people still living in countries of origin. This increased the possibility of applicants being removed to countries where their protection is disputed. Service providers argued that the RRT assessment of protection risks in countries of origin should be improved to ensure reliable and adequate information is being used to assess refugee status.

IMPACT OF LACK OF CONFIDENCE IN THE ASSESSMENT PROCESS

Service provider: [T]he [removal] process breaks down when you don't trust the assessment process. You actually need to be able to say [to a client], 'Well, we've really got confidence in the Refugee Review Tribunal, they've got access to the latest information. They reckon a person like you in fact won't be persecuted in your country' and if you could believe that then you'd really have some grounds to work with the person and say 'Ok, you've been traumatised in the past but the situation's changed so we've got to help you work on the idea that it is safe now. I know you're basing your fear on what's happened to you previously, so that's understandable you perceive it in that way. We're going to have all these things in place for you to support you.'

LENGTH OF TIME WAITING IN UNCERTAINTY

As with other aspects of the application process, the length of time it took to receive a decision from the RRT was seen to have a significant impact on the mental health and wellbeing of asylum seekers. The impact of waiting in uncertainty has been described in previous sections. This issue is compounded when the applicant has no access to basic support or health care.

This issue has been recognised by the RRT, and a 90 day time standard has been introduced for

all RRT cases. In 2005-2006, the RRT averaged 59 calendar days for processing applications for people in detention, and 99 calendar days for processing all other cases. This had improved from previous years.

These improvements in timeliness should not be at the cost of the quality of decisions made by RRT members. Concerns regarding the high work load of RRT members have previously been noted due to the potential impact of this pressure on the quality of decisions (Senate Legal and Constitutional References Committee, 2000).

RESPONSE OF COMMUNITY SECTOR

In response to these issues, the community sector has attempted to support asylum seekers as they proceed through the RRT review process by:

- Arranging and providing legal and migration advice when able.
- Providing reports where appropriate.
- Providing moral and emotional support.

RECOMMENDATIONS

To improve RRT decisions, and promote better care of asylum seekers through the review process, we recommend:

- 4.7.1 Ensuring all RRT members make use of the Tribunal's new guidelines regarding credibility.
- 4.7.2 Establishing more reliable information sources regarding the situation in countries of origin.
- 4.7.3 Meeting the 90 day standard for Tribunal decisions.
- 4.7.4 Training RRT officials on the effects of the refugee experience on individuals.
- 4.7.5 Establishing a consistent RRT staff culture of objective compassion and respect, especially in the interview situation.

4.8 Immigration Minister's discretion and compassionate grounds

There are some individuals in Australia who have sound humanitarian reasons for being unable or unwilling to return to their country of origin but who do not require protection under the Refugee Convention and are ineligible for any particular visa offered in Australia. Prior to July 1993, many individuals in this situation would have been eligible to apply for an on-shore humanitarian visa, which was open to applicants who had strong compassionate or humanitarian reasons for needing residency in Australia. Now the only option available is to apply to the Minister for Immigration to make use of his discretionary powers to grant a visa. Under Section 417 of the *Migration Act 1958*, the Minister is endowed with non-delegable, non-reviewable and non-compellable powers of discretion. These powers enable him to substitute a more favourable decision for a decision made by a review Tribunal if he considers it to be in the public interest. These powers are designed to provide a safety net for individuals who have legitimate reasons to remain in Australia.

Although the Minister is not bound to disclose the reasons for his decisions, the guidelines found in Migration Series Instruction 386 (MSI-386) provides some insight regarding the implementation of these powers (Department of Immigration and Multicultural Affairs, 2003). The guidelines note that these powers are for cases that exhibit one or more unique or exceptional circumstances. The following situations are among the circumstances considered relevant:

- A significant threat to an applicant's personal security, human rights or human dignity on return to their country of origin;
- Substantial grounds for believing a person may be in danger of being subject to torture;
- Circumstances that may invoke Australia's obligations under *Convention on the Rights of the Child* (CROC);

- Circumstances that may invoke Australia's obligations under the *International Covenant on Civil and Political Rights* (ICCPR). This may include, for example, if the person would face a real risk of:
 - violation of his or her right to life (article 6);
 - violation of his or her right to freedom from torture and cruel, inhuman or degrading treatment or punishment (article 7);
 - facing the death penalty (no matter whether lawfully imposed).
- Strong compassionate circumstances such that a failure to recognise them would result in irreparable harm and continuing hardship to an Australian citizen or an Australian family unit;
- Circumstances where exceptional economic, scientific, cultural or other benefit to Australia would result from the visa applicant being permitted to remain in Australia;
- The length of time the person has been present in Australia (including time spent in detention) and their level of integration into the Australian community;
- Compassionate circumstances regarding the age and/or health and/or psychological state of the person.

This is a significant list of issues that may invoke the Minister's powers, yet little advice is given as to how to negotiate the disparate and competing needs it covers. In addition, the Minister must consider an applicant's circumstances against the potential impact his decision may have on the Australian public. When considering an application, 7.0.4 of MSI 386 notes the Minister must be kept informed of "any cases that may amount to a potentially high health cost to the Australian community" (Department of Immigration and Multicultural Affairs, 2003). The public health criteria 4007 found in Schedule 4 of the *Migration Regulations 1994* can contribute to our understanding of how this cost is understood, including taking into consideration whether the decision is likely to:

- result in an undue cost to the Australian community; or
- unduly prejudice the access of an Australian citizen or permanent resident to health care or community services.

The calculation of the costs associated with an applicant's ill health may mean that those individuals with the most significant health issues may be less likely to be granted a visa on compassionate grounds through Ministerial intervention. This harsh irony is unconfirmed in practice. Although the Minister regularly reports to the Parliament on the use of discretionary powers, these reports contain few details. As a result, very little is known or understood about the factors that most sway the Minister when considering applications. Two recent Senate inquiries flagged this dilemma, observing that no substantial conclusions can be made regarding the Minister's reasons for granting particular visas under Section 417 and calling for more information to be provided to Parliament by the Minister to ensure greater scrutiny of the use of the powers (Senate Legal and Constitutional References Committee, 2006; Senate Select Committee on Ministerial Discretion in Migration Matters, 2004).

IMPACT OF MINISTERIAL DISCRETION ON HEALTH

Several aspects of the current application of Ministerial discretion were identified through the research for their detrimental impact on the health of asylum seekers (listed in Table 4.7).

TABLE 4.7: IMPACT OF MINISTERIAL DISCRETION ON HEALTH

Aspects of Minister's discretion which impact health	Impact on health
<ul style="list-style-type: none"> • Lack of consistency in decisions regarding humanitarian or compassionate circumstances, including irregular use of compassionate circumstances to grant a visa to someone who is seriously ill. • Human rights obligations are not applied in a consistent manner. • Lack of communication and transparency of reason for decisions. • Length of time waiting in uncertainty with no rights or entitlements. 	<p>Contribution to the onset of mental health issues.</p> <p>Deterioration of mental health issues.</p> <p>Negative impact on families including higher levels of conflict due to high levels of stress and uncertainty.</p> <p>Health at risk if <i>refoulement</i> occurs.</p> <p>Decision to provide a temporary visa leads to limited positive impact: allows some treatment but continues uncertainty and does not allow family reunion.</p>

LACK OF CONSISTENCY IN DECISIONS REGARDING COMPASSIONATE CIRCUMSTANCES

Service providers had experienced great variation in success amongst clients who applied to the Minister, and were keenly aware that Ministerial decisions were inconsistent across applications. They argued that it was unclear why they had some exceptional cases where applicants would succeed when others with equally strong cases would not be granted a visa. As a result, service providers felt unable to advise their clients about the most likely outcome of an application and to assist them in undertaking appropriate preparation for the future. This discrepancy created confusion and a sense of injustice for service providers who were afraid for individuals and families whose life and health would be under great threat in countries of return.

Service providers need a clearer and more consistent decision making process to aid them in advising clients about whether to apply to the Minister, and in preparing clients for application outcomes. The current decisions made by Ministerial intervention means many applicants who have valid and grave concerns for their health on removal are unable to avoid the devastating consequences of return. A stronger application of Ministerial intervention on compassionate grounds is needed, especially when the illness is the result of, or has been aggravated by, experiences in Australia and will be left untreated on return. More comprehensive guidelines for negotiating decisions relating to health and compassion would assist the Minister and his staff in maintaining strong and consistent decisions regarding compassion without compromising the level of control exercised by the state.

INCONSISTENCIES IN MINISTERIAL INTERVENTION

Service provider: So this was a ... woman who was very unwell, actually had a psychotic illness and I'm pretty sure that her illness played a big part in – she was in detention – in her being granted a visa on humanitarian grounds because she ... couldn't cope in the community here ..., she needed extensive support. The interesting thing is it doesn't seem to be applied in a systematic way, because I couldn't see, I mean she had a very compelling case but I really couldn't see what it was that distinguished her from a whole lot of other people.

INCONSISTENCY IN THE APPLICATION OF HUMAN RIGHTS OBLIGATIONS

Some service providers were gravely concerned when they felt that the human rights of their clients were at risk on removal. Many service providers did not feel confident that the risk of human rights violations were being accurately assessed and acknowledged, a belief fuelled by the fact their own assessment of risk of human rights violations for their clients rarely coincided with the decision passed down by the Minister. As a result, service providers' fears on behalf of their clients were not allayed by confidence in the Minister's decisions. This was particularly troubling for service providers whose clients had previously experienced human rights violations in their country of origin, such as torture, but whose fears were still considered unfounded (Coffey, 2003). Many felt that the use of Ministerial intervention

to uphold fundamental human rights was a poor substitute for a systematic procedure to accurately and consistently assess threats to rights on return. This concern has been noted in other literature (Catholic Commission for Justice Development and Peace, 2003; Schloenhardt, 2002) and was flagged in the Senate Inquiry on Ministerial Discretion, which found that family ties represented a greater proportion of visas granted under these powers: “This appears to suggest that compassionate considerations such as family ties in Australia are more likely to result in the grant of a visa than humanitarian need” (Senate Select Committee on Ministerial Discretion in Migration Matters, 2004; p. 41).

The removal of an individual or family to a place in which their human rights will be violated will have a tragic impact on health. There is consensus amongst health researchers that human rights violations have a negative impact on health (Farmer, 1999; Moreno, Piwowarczyk, & Grodin, 2001). As a result it can be argued that any instance of return that leads to a violation of an individual’s human rights will have an impact on health and wellbeing. Some violations, such as torture, may have a more significant and pronounced impact on health than others. Other rights violations will be compounded by poverty and situations of ongoing violence and conflict.

LACK OF TRANSPARENCY OF DECISIONS

The apparent lack of consistency in Ministerial interventions is obscured by a lack of information available regarding the reasons for both positive and negative decisions. An applicant is not given a reason for a decision, but is informed through a brief letter stating the decision and its consequences, and parliamentary reporting has been sparse in its detail. For service providers, this complicates their work with asylum seekers who are dealing with the outcomes of their applications. For asylum seekers, the lack of information regarding decisions can mean that they do not feel that their concerns have been heard or recognised. This can have a substantial impact on their willingness to undertake removal, with significant consequences for service providers and compliance officers.

Some service providers were concerned that their experience suggested the Minister was most likely to make a favourable decision towards an applicant to avoid negative publicity. Several service providers were uncomfortably aware of cases that had received intervention after advocates had threatened to publicise the circumstances of the applicant. This concern is not inconsistent with the positive outcome of some recent cases that have been publicised through the media, such as the granting of a permanent visa through Ministerial intervention for an 104 year old Chinese woman who had been living on bridging visas without medical care due to being unfit for travel for almost 10 years (The Age, 2005).

LENGTH OF TIME WAITING IN UNCERTAINTY

As with the previous stages of the asylum process, there are concerns about the length of time it takes for the Minister to hand down a decision on applications for intervention. As demonstrated earlier in this chapter, there is much descriptive evidence suggesting that the length of time waiting in uncertainty is linked to the decline and deterioration of health and wellbeing amongst asylum seekers. This evidence extends to the experience of waiting for a final decision from the Minister. Service providers were concerned that levels of anxiety and distress were higher amongst individuals applying to the Minister, as this is the final option for obtaining a visa to remain in Australia. The experience of service providers was that this period of waiting was most distressing and traumatic for asylum seekers, and that few interventions offered at this stage provided significant alleviation of this distress. This was compounded by, and related to, the fact that no welfare or medical support was provided to asylum seekers who had made an application to the Minister.

In some cases, service providers felt that the Minister deliberately delayed making a decision while their client was unfit to travel. Some clients who had applied to the Minister for intervention on medical grounds had waited for numerous years until their case was resolved (see, for example, Case Study 4). During this time, they remained on rolling bridging visas in the community while they

waited for a decision. The effective result is that while they were unable to travel due to their health, they were not allowed to obtain medical treatment, receive income or housing support, or see family who remained overseas. As a Ministerial decision, and removal, could occur at any time, applicants were kept in a state of high anxiety and precariousness for long periods creating a further debilitation of their mental health and wellbeing. Service providers felt that clients who were permanently unfit for travel had only been able to obtain a visa after a long and burdensome period of waiting and advocacy. They argued that a more practical and humane approach would see a permanent solution negotiated within a more reasonable time period.

LENGTH OF TIME WAITING FOR A MINISTERIAL DECISION

Service provider: I might start with a ... man ... he has intestinal cancer. He came to us two years ago when he was just diagnosed and had an operation and I think he's had an operation since. He still remains with the cancer but he's being treated with a lot of different medications which have been, at the moment because of his lack of Medicare, they're being provided to him for free through his local physician. He's waiting for the Minister and he's been waiting for pretty much that amount of time, so for two years, without a response.

Another factor contributing to the length of time spent in Australia is that if someone arrives in Australia on a valid visa and has the misfortune to experience a serious illness after arrival, there is no established process for obtaining a visa to remain in Australia on medical grounds. Often the only real option is to apply to the Minister to intervene on compassionate grounds. However, this cannot be done without first being rejected at both the primary and review stages of a visa application. This means those who are clearly not going to be recognised as refugees must progress through the long bureaucratic process of primary assessment and review before being able to make an application to the Minister. This seems an unnecessary waste of Department resources and time, while placing the mental and physical health of the applicant at great risk.

DISCUSSION – COMPLEMENTARY PROTECTION

One of the failings of the current system is that the health care needs of asylum seekers that arise as a result of their experiences in Australia are not clearly acknowledged and taken into account. There is no evidence that the Minister gives greater weight to the circumstances of those who have been most affected by the asylum process. This is a serious neglect of responsibility for those who have had their physical and/or mental health compromised by processes designed and continued by the Australian government. Recognition of the impact of this process would ensure that asylum seekers with such health issues would not be returned unless the level of support and health care needed to redress this impact on health is available on removal.

Two Senate inquiries have recommended that the *Migration Act* be amended to introduce a system of 'complementary protection' for future asylum seekers who do not meet the definition of refugee but who otherwise need protection for humanitarian reasons (Senate Legal and Constitutional References Committee, 2006; Senate Select Committee on Ministerial Discretion in Migration Matters, 2004). Such a system would create a systematic and reliable assessment of human rights obligations that may be afforded to those who are not refugees. A complementary protection system could also assess the need for humanitarian intervention and compassionate response for those whose circumstances would be intolerable on return. Such a system would reduce the workload of DIAC by ensuring that people with humanitarian needs can be assessed at the first instance of application, rather than having to be refused at the primary and review level before being personally assessed by the Minister. This can undermine the credibility of the protection application process derived from the Refugee Convention by mixing refugee-related applications with applications based on compassionate grounds. The current system

wastes significant time and resources and forces those with humanitarian concerns to go through the difficult and often damaging asylum process in Australia. This has a counterproductive effect when it comes to removal due to the deterioration of health issues over time, the establishment of links with members of the Australian community and the lack of personal financial and emotional resources remaining to undertake return.

Although the concept of complementary protection has received only minimal attention in the Australian context (Refugee Council of Australia, 2004), the need for structures to assess these protection needs has been identified by many in the international community (European Council on Refugees and Exiles, 2000). Complementary protection (also known as ‘subsidiary protection’) has been established in Europe through the introduction of *non-refoulement* obligations outside the Refugee Convention that emanate from, among other instruments, the European Convention on Human Rights (ECHR). European states have been implementing these systems with varying success (European Council on Refugees and Exiles, 2003). Canada makes use of a single protection system to assess complementary protection needs alongside refugee protection needs (Dolin & Young, 2002). UNHCR has assisted with the development of the concept through several discussion papers dealing with protection needs that fall outside the Refugee Convention (Mandal, 2005; McAdam, 2005).

Ministerial discretion provides the only viable opportunity for a seriously ill applicant to be granted a visa on compassionate grounds. It is disappointing that this opportunity is not taken up more readily, and with more consistency and transparency, by the Minister. It is also concerning that these discretionary powers are used to implement a range of human rights obligations. We encourage the government to investigate the benefits of establishing a stronger system of complementary protection.

RESPONSE OF COMMUNITY SECTOR

Community sector responses aimed at minimising the impact of Ministerial decisions on the health of asylum seekers include:

- Arranging and providing for basic needs, such as housing and health care.
- Arranging and providing legal and migration advice.
- Arranging and providing specialist assessments to support applications.
- Arranging and providing letters of support for applications.
- Providing moral and emotional support to applicants.

RECOMMENDATIONS

To increase the effectiveness of Ministerial decisions in dealing with humanitarian and compassionate issues, we recommend:

- 4.8.1 Creating a system of ‘complementary protection’ so that human rights issues and humanitarian concerns can be assessed at an earlier stage of the process.
- 4.8.2 Strengthening the quality and consistency of Ministerial decisions.
- 4.8.3 Developing a faster decision making process for the Minister.
- 4.8.4 Providing legal advice to applicants to ensure applications contain all relevant information.
- 4.8.5 Ensuring reasons for decisions are transparent to the applicant and to the public.
- 4.8.6 Ensuring the level of health care on return is considered, especially for applicants whose health has deteriorated significantly during the asylum process in Australia.
- 4.8.7 Introducing human rights conventions into federal legislation.
- 4.8.8 Providing applicants with support for basic needs such as housing and health care while applications to the Minister are assessed.

4.9 Conclusion

This chapter has outlined the ways in which the health of asylum seekers is compromised as a result of the asylum process in Australia. The impact on health has been linked to both the bureaucratic processes established to deal with asylum claims in Australia, as well as to specific limitations placed on asylum seekers' access to health care and basic resources while waiting for these administrative processes to be completed. Although we have outlined the specific impacts of a variety of aspects of the asylum system on health, there are some overarching issues that most impact health:

- Length of time waiting in uncertainty
- Restricted access to health care
- Restricted access to work rights
- Restricted access to basic income and housing
- Long term, indefinite detention

As has been shown, asylum seekers' health can be compromised in multiple ways as a result of processes established and maintained by the federal government. The potent and compelling argument for change comes from realising that not only is the level of health care access among asylum seekers vastly less than the access enjoyed by the rest of the population in Australia, but that the asylum process in and of itself is a core cause of health issues amongst this population.

There is no reason why the asylum process should have such a damaging effect on health and wellbeing. As one service provider said,

"...how I look at it is this is all needless suffering. You know, there's enough suffering in the world but we can't do anything much about it and this is needless suffering...it's absolutely immoral."

The government has a responsibility to ensure that its policies are not needlessly damaging. Seeking asylum in Australia has a specific and tragic impact on the health of asylum seekers. It is clear that changes must be made to ensure that the asylum process in Australia does not cause harm to those individuals who experience it in practice.

Current policies and practices create significant practical dilemmas for removals by contributing to serious illnesses in removees. The impact of policies on health also introduce a greater responsibility to the removee, to ensure that health issues induced or compounded while in Australia can be adequately treated on removal. Improvements in the asylum process would ease some of the issues currently experienced when removing asylum seekers who are seriously ill.

5. Serious illness and removal from Australia

Removal is a difficult end to an asylum assessment process. Australia fails to adequately incorporate health and welfare concerns in its removal policies and practices. Asylum seekers must be supported to undertake voluntary return whenever possible. Health and welfare issues, non-refugee protection needs and the context on return all need to be considered in removal decisions and procedures. Healthier removal policies would systematically recognise human rights and compensate for failures in duty of care. Removal policies also need to incorporate the fundamental elements of compassion and respect.

The previous chapter has traced the numerous ways policies in Australia can compromise the health of asylum seekers. As a result, serious illnesses can become established and compounded during the asylum process. Mental health is particularly vulnerable to the adverse conditions experienced in Australia. This chapter deals with the practical and ethical dilemmas that arise as a result of such health issues at the point of removal.

We start by examining the removal process and the limited options available for independent return. We then explore the limits placed on health care while awaiting removal and its impact on those who wait for long periods for travel to become possible. The discrepancy in fitness to travel assessments is discussed, pointing to the need for a more comprehensive health assessment to shape return decisions and processes. The management of ill health during the removal event itself is then considered, followed by an examination of on-arrival procedures and the need for handover of care arrangements. Finally, the ongoing health care and situation in countries of return is discussed alongside the implications for decisions regarding removal. We conclude by examining three frameworks that can be used to consider our responsibilities and opportunities when engaging with this complex moral and political situation: human rights, duty of care and compassion.

5.1 The removal process: Voluntary versus involuntary departure

Once any application for a visa in Australia has been refused and fully determined at all levels, and any valid visa has expired, an individual becomes an ‘unlawful non-citizen’. Section 198 of the *Migration Act* provides for the removal of unlawful non-citizens in particular circumstances ‘as soon as reasonably practicable’. The level of involvement of Department officials in effecting this removal depends greatly on an individual’s circumstances and willingness to leave Australia: the largest proportion of unlawful non-citizens removed are bridging visa overstayers and visitor visa overstayers, and the majority of these leave voluntarily with only minimal contact with the Department (Department of Immigration and Multicultural and Indigenous Affairs, 2004). The range of removals, as described by DIAC, includes:

- **Left Australia unlawful departure** – an individual voluntarily leaves Australia while unlawful without reporting to DIAC first. This removal is self-funded.
- **Monitored departure** – an individual is granted a bridging visa to arrange their own departure. DIAC checks immigration systems to ensure the person departed. This removal is self-funded.
- **Turnaround removal** – After a screening process at a port of entry, an individual is removed from the airport detention facility. This removal is funded by the carrier (airline).

- **Supervised departure (unescorted removal)** – After being detained, individuals are accompanied to the airport to ensure boarding on a flight but are not escorted on the flight. This removal is funded by the removee or by DIAC but with the removee liable to repay the expense.
- **Escorted removal** – After being detained, individuals are escorted for the entire journey until arrival in destination country. This removal is funded by the removee or by DIAC but with the removee liable to repay the expense.

Supervised departures (unescorted removals) are not considered appropriate for persons who require a medical escort (Department of Immigration and Multicultural Affairs, 2005d).

We also note that there is an option for fully independent departure:

- **Lawful voluntary departure** – Individuals arrange and purchase their own travel, and depart Australia while on a valid visa thereby not requiring detention and escort.

VOLUNTARY DEPARTURE OPTIONS FOR REFUSED ASYLUM SEEKERS

For people who have been through the asylum process, independent departure is a rare opportunity. For those who are willing to undertake voluntary removal, there are few options to achieve an independent return journey. The majority of asylum seekers facing removal are destitute after years of living without an income or the right to work, and are unable to pay for their own airline ticket. Any DIAC assisted removal is dealt with as a formal removal, and results in detention, a debt to Australia, losing control over travel documents during the journey, as well as formal notification of the removal to airlines, countries of transit and even, occasionally, countries of return.

These conditions can have a big impact on an asylum seekers' willingness to participate in removal procedures (Asylum Seeker Project Hotham Mission, 2006). The impact of the asylum experience in Australia can mean asylum seekers facing removal are afraid of further detention due to previous traumatic detention experiences, distrustful of Department officials and the information they provide, and living with heightened levels of anxiety and distress. Asylum seekers also have a real sense of fear for their safety and wellbeing in their country of origin, even though this fear has not led to recognition as a refugee.

The combination of these issues can create a very difficult situation for caseworkers and compliance officers who are trying to ensure departure is achieved smoothly without resulting in a traumatic and high risk enforced departure. Some community organisations have managed to obtain enough donations for some clients to undertake an independent return journey to allow a greater sense of control and security on arrival.

The promotion of voluntary removal is Guideline 1 in the *Twenty Guidelines on Forced Return* adopted by the Council of Europe (Council of Europe, 2005). These guidelines are a pragmatic document to be used by European states to develop appropriate legislation and practices for the removal of non-citizens that conform with human rights agreements adopted by member states of the European Union. As such, they provide clear stipulations for establishing minimum standards for return procedures.

USE OF INVOLUNTARY REMOVAL

Some asylum seekers facing removal are unwilling to participate in removal procedures, especially those who have a strong sense of fear for their safety on return; who feel their situation has not been acknowledged and fully considered by the Australian government; and for those who are mentally unwell. This is a difficult issue for DIAC compliance officers to resolve, as they have few avenues for negotiation. Forcing an individual to leave the country is a difficult undertaking that can involve physical force, and places the removee and his/her escorts at risk. Some service providers were concerned that coercion and threats of involuntary removal or indefinite detention are used to force an unwilling removee to

accept removal against their own judgement. Although the few financial repatriation packages offered through the International Organization for Migration (IOM) to some detention populations have had some influence in encouraging removees to undertake removal, service providers were concerned that these had been offered as the only alternative to threats of indefinite detention. This has been disputed by DIAC in relation to Iranian removees (House of Representatives, 2005: p 347). Service providers felt that some clients in this situation were unable to make good decisions regarding their future and removal largely as a result of their extremely vulnerable and frail state of mind, and that forced removal would place them at risk of further mental deterioration.

The impact of enforced departures can be great for those who are suffering from mental health issues. This has been recognised in the policies of a number of countries regarding the forced removal of refugees who were no longer considered in need of protection: “Since November 2000, Bosnian refugees who could document that they were severely traumatised and were therefore receiving psychotherapeutic or psychiatric treatment have the right to stay in Germany” (Luebben, 2003: p. 396). Austria also accepts that forced return can have an unacceptable impact on the health of vulnerable individuals, deciding that “traumatized refugees, especially those suffering from post-traumatic stress disorder (PTSD), should not be subjected to forced repatriation...[F]orced repatriation could lead to retraumatization and worsening of symptoms” (Mirzaei, Lipp, Rodrigues, & Knoll, 2003). In these countries, the impact of forced removal on mental health is considered before removal is undertaken.

WOMAN WHOSE MENTAL HEALTH COLLAPSED ON NOTICE OF REMOVAL

Service provider: *[T]here was a woman who had an RPBV or a Resident's Determination, whichever one, of all the people they would select to be the first one to be deported was this Iranian woman and her child. This woman is so vulnerable, 3 years in detention has wrecked her, she's been slashing her arms, she has attempted suicide twice, she is very psychologically vulnerable. They sent her a letter on the Friday telling her to go into DIMIA because she had to leave the country. She goes into DIMIA and they tell her she's got to buy a ticket and leave in fourteen days. She collapsed and had to be taken to [hospital] where she's in a psychotic state. Her child had to be placed in care. Now if you want an illustration of how the Department hasn't changed, of all the people they would pick to do this on, why would they pick her? Why wouldn't they, knowing her medical and psychological history, why would they do it that way?*

RESPONSE OF COMMUNITY SECTOR

Service providers in the community have attempted to support asylum seekers facing removal by:

- Raising funds through donations to allow voluntary return when appropriate.
- Advocating for greater use of voluntary return options and repatriation packages by DIAC.
- Providing emotional support and counselling for those approaching removal.

RECOMMENDATIONS

To increase support of voluntary returns, we recommend:

- 5.1.1 Ensuring a comprehensive funding system is in place to support voluntary return without the use of detention.
- 5.1.2 Making use of reintegration packages to support returnees on arrival. This should be offered without the use of threats.
- 5.1.3 Using comprehensive case management of return.
- 5.1.4 Improving the asylum process so that returnees are well enough to deal with the practical and emotional difficulties of undertaking return.
- 5.1.5 Using detention pending removal only as a last resort once all attempts at voluntary return have been exhausted.

5.2 Access to health care while awaiting removal

Section 198 of the *Migration Act* provides for the removal of ‘unlawful non-citizens’ “as soon as reasonably practicable”. Despite this directive, it can be difficult for officers to arrange an immediate removal for a variety of reasons ranging from minor practical difficulties, such as a lack of seats on flights, to serious obstacles that arise, such as when no country will recognise the individual as its citizen. For this reason, removees may be in Australia without a visa application pending for varying lengths of time. This section describes the most common situations of removees awaiting removal, and the health care available during this time.

BRIDGING VISAS

If an asylum seeker is living in the community on a bridging visa when a final decision is made, they will continue to live in the community until that visa expires, they choose to depart the country or they are taken to detention in preparation for removal. Some asylum seekers may apply for a further bridging visa to enable them to make their own arrangements for removal after a final decision. An asylum seeker becomes an ‘unlawful non-citizen’ when their bridging visa expires.

Most asylum seekers living in the community who have completed the final stage of application will be living on a bridging visa with no work rights or access to Medicare, and no access to federal income support. The impact of these conditions on health is described in detail in section 4.3. For asylum seekers who are considered ‘unfit for travel’, this can result in their living in the community for long periods of time waiting for their health to improve to undertake removal, but without any health care.

DETENTION

Asylum seekers who arrive in Australia without a valid visa can be held in detention until their protection application is fully resolved. Some asylum seekers are consequently in detention when a final decision on their application is made. Asylum seekers who have been living in the community when their application is finally resolved may be taken to detention at any stage as the first step in the removal process.

As a result, these asylum seekers are provided with the health care that is available to all detainees. The quality and impact of the health care available in detention is described in detail in section 4.2.

The use of detention in the removal process raises significant issues for asylum seekers. Many have previously been detained and are terrified at the prospect of returning to a site of such trauma and distress. This can cause significant issues for compliance officers who must manage difficult and sometimes violent behaviour of people who are terrified of further detention.

RETURN PENDING VISA

This visa was established to enable “persons previously holding a temporary protection (TPV) or temporary offshore humanitarian (THV) visa, and found to no longer be owed protection, time to make departure arrangements to return home” (Department of Immigration and Multicultural Affairs, 2006c). This visa allows eligible persons to remain in the community for up to 18 months on the same visa conditions as the TPV and THV. Such benefits include:

- Access to Medicare;
- Work rights;
- Eligibility for Special Benefit, Health Care Card, Rent Assistance, Family Tax Benefit, Child Care Benefit, Double Orphan Pension, Maternity Allowance and Maternity Immunisation Allowance;
- Eligibility for torture and trauma counselling.

The RPV does not allow sponsorship of family members.

Although this visa provides some minimal support to individuals living in the community, the

visa is only offered to individuals who, despite previously being recognised as a refugee with valid protection needs, have been forced to live in Australia on a temporary basis without the ability to be reunited with their family. The impact of the temporary protection visa on health has been outlined in other research (Correa-Vélez et al., 2005; Marston, 2003; Momartin et al., 2006; Taylor, 2005a).

REMOVAL PENDING BRIDGING VISA

The Removal Pending Bridging Visa (RPBV) was introduced to “enable the release, pending removal, of people in immigration detention who have been cooperating with efforts to remove them from Australia, but whose removal is not reasonably practicable at that time” (Department of Immigration and Multicultural Affairs, 2006e). Most people who have been granted this visa have lived in detention for long periods of time. Detainees who may be eligible for the visa are invited to apply by the Minister. The visa includes, among others, the following benefits:

- Access to Medicare;
- Work rights;
- Eligibility for certain Centrelink benefits such as Special Benefit and Rent Assistance;
- Eligibility for torture and trauma counselling.

The RPBV does not allow for sponsorship of family members.

Despite the social support that is available to individuals living in the community on these visas, these benefits will do little to restore the health of those whose physical and/or mental health has been largely compromised through the experience of long-term detention. The RPBV further compounds these health issues by prolonging the period of uncertainty for those who have spent years trying to find a permanent place of residence.

TEMPORARY SAFE HAVEN VISA

During 1999, the Australian government established the Temporary Safe Haven visa category to enable the temporary entry into Australia of 4000 Kosovars who were being evacuated from their region after an outbreak of violence. It allowed the Kosovars special entry into Australia for an initial period of 3 months. This visa was also used in September 1999 to allow the temporary entry of 1900 East Timorese in similar circumstances (Department of Immigration and Multicultural Affairs, 2005a). The visa places strict limits on the options for individuals to obtain permanent residency in Australia: they must be invited by the Minister for Immigration to apply for a visa. The majority of Kosovar Safe Haven visa holders were returned by 2000, some after pursuing legal action to prevent their removal to an area still considered unsafe and unprepared for returnees (Head, 2000). Few were invited by the Minister to apply for another visa. The remaining individuals have been unable to return due to ill health or other circumstances and have continued to live in the community on rolling one or two year Safe Haven visas. As at 30 June 2005, there were 14 persons who still held Safe Haven visas (Department of Immigration and Multicultural and Indigenous Affairs, 2005). This visa has restricted work rights but no access to Medicare or most Centrelink benefits.

All individuals who arrive in Australia on this visa are expected to return to their country of origin. As a result, Safe Haven visa holders live in Australia awaiting removal. For those who are seriously ill, or who have valid protection or human rights concerns preventing their return, the visa keeps them living in a state of uncertainty.

RESPONSE OF COMMUNITY SECTOR

The community sector has tried to support asylum seekers in this situation by:

- Providing for basic needs through housing, income, food and medication when needed.

- Establishing free medical clinics.
- Arranging *pro bono* medical services from private practitioners.
- Providing medication and medical equipment.
- Advocating for a change in policy at the state, territory and federal levels.

RECOMMENDATIONS

To maintain the health and wellbeing of those awaiting removal, we recommend:

- 5.2.1 Ensuring basic needs, such as income and housing, are provided while awaiting removal.
- 5.2.2 Ensuring health care is available throughout the entire asylum process.
- 5.2.3 Replacing Removal Pending Bridging Visas with a permanent solution.

5.3 Health and removal: “fitness to travel” vs. “fitness to return”

The Department requires that all detainees departing Australia must be cleared as being fit to travel (Department of Immigration and Multicultural Affairs, 2005d). Fitness to travel is also assessed for community-based removees when they or their representative raise concerns about their ability to travel. This is consistent with the policies of most airlines that require a ‘fitness to travel’ certificate for any passenger who may have, or display, any significant health issues (British Airways, 2004; Qantas Airways Limited, 2005). This requirement is designed to prevent any medical emergencies during flight, thereby ensuring the health and safety of individual passengers, as well as maintaining a safe and uninterrupted flight for all passengers. The *Medical Guidelines for Airline Travel* (Aerospace Medical Association, 2003) recommend that, “[a]s a general rule, an individual with an unstable medical condition should not fly. Instability combined with the stresses of flight could pose a serious threat to the health and well-being of the sick or injured traveler (*sic*)” (p. A2). Aspects of fitness to travel assessments that have a detrimental impact on the health of asylum seekers are presented in Table 5.1.

TABLE 5.1: FITNESS TO TRAVEL ASSESSMENTS

Aspects of fitness to travel assessments that impact health	Impact on health
<ul style="list-style-type: none">• Fitness to travel assessments by Health Services Australia contradict assessments by the treating medical practitioner.• Mental health issues are not systematically considered unless they raise a high possibility of interruption to the flight.• Removal is threatened, attempted and sometimes completed despite blatant ill health.	<p>Travel may be a great health risk for someone who is seriously ill.</p> <p>Removal event can trigger a ‘crisis’ in mental health.</p>

DISCREPANCIES IN FITNESS TO TRAVEL ASSESSMENTS: HSA ASSESSMENTS

When the Department is advised that a removee is considered unfit for travel, an assessment is undertaken by Health Services Australia (HSA). HSA is a company wholly owned by the Australian government that undertakes health assessments in a range of situations, such as work place health and safety services and medical assessments for immigration applicants (Health Services Australia, 2002). This assessment must be paid for by the applicant.

Service providers interviewed were concerned that the fitness to travel assessments undertaken by HSA conflicted with the assessment by the client’s attending health professional. This discrepancy suggests there is not a clear standard for assessing the health status of someone undertaking international travel. In some instances, the number of fitness to travel assessments undertaken for an individual removee caused service providers to accuse the Department of ‘report shopping’ until fitness to travel had been assured. Concerns have also been raised regarding the use of IOM employees for undertaking health assessments for detainees on Nauru (Corlett, 2005).

Service providers were keenly aware of the relatively broad definition of fitness to travel used by HSA. They felt that HSA provided a certificate of fitness to travel if the individual was physically able to board an aircraft and survive the flight without incident, sometimes with the use of medication. This approach to fitness to travel differed from the approach of treating doctors whose assessment of fitness to travel focused on the impact of the journey on the overall health and wellbeing of their patient. This discrepancy has led to a high level of mistrust between treating doctors and the health assessments undertaken on behalf of DIAC.

Questions surrounding HSA health assessments were raised in public in 2005 after an elderly Syrian visitor from Lebanon died in Melbourne two days after she was assessed by HSA as being fit to travel. This assessment differed from the advice of her treating doctor, who had informed DIAC that she may be permanently unable to travel, and had recommended the woman remain confined to her home. The case came to the attention of the media after her attending doctor recorded her cause of death as ‘harassment’ by DIAC (Jackson, 2005b). An investigation by the Commonwealth Ombudsman included recommendations for DIAC and HSA to “review the instructions provided to HSA medical examiners to ensure that the scope of the task is clear and that there are consistent criteria for the assessment of fitness to travel, particularly in relation to frail aged persons” (Commonwealth Ombudsman, 2006a: p. 5). The report also identified a number of deficiencies in the Department’s processes including their “repeated failure to identify, or give adequate consideration to, Mrs Agha’s circumstances” (Commonwealth Ombudsman, 2006a: p. 2).

Concerns regarding fitness to travel assessments had already been raised by the Commonwealth Ombudsman when investigating the Vivian Alvarez Solon matter. The Inquiry recommended that medical practitioners who are undertaking fitness to travel assessments should: receive the medical history and records of the unlawful non-citizen; should be, if possible, someone who has previously treated the patient; and should be advised of the factual circumstances that have led to the need for the medical examination (Commonwealth Ombudsman, 2005).

MENTAL HEALTH AND FITNESS TO TRAVEL ASSESSMENTS

Service providers were also concerned that fitness to travel assessments do not appear to include an assessment of the mental health and wellbeing of a patient. Given the impact of the asylum process on the mental health of many asylum seekers, this absence neglects Australia’s responsibility for an individual’s mental health and the potential impact of removal. The importance of assessing mental health when considering travel is reflected in the *Medical Guidelines for Airline Travel* (Aerospace Medical Association, 2003) which state that “[p]ersons with psychiatric disorders whose behavior is unpredictable, aggressive, disorganized, disruptive or unsafe should not travel by air. Patients with psychotic disorders who are stabilized on medication and are accompanied by a knowledgeable companion may be able to fly” (p. A13).

SUICIDAL REMOVEE

Service provider: ... *there was a bloke, he was really unwell He was suicidal and both myself and [name] assessed him as being suicidal and he just got deported... In the days before he was deported, he was in a management unit room, an observation room, and they’d taken everything from him. They wouldn’t even leave a Bible in his room because they said he might tear the pages out and choke himself. So that’s the extent they were admitting he was at risk but nonetheless he was deported. We don’t know what’s happened to him but we... said that we can’t be at all be sure that he’s going to survive ... because he’s making quite explicit threats against his life.*

ATTEMPTS TO REMOVE DESPITE BLATANT ILL HEALTH

Service providers were concerned by threats to remove, attempts to remove, or the successful removal of individuals who were blatantly unwell and unable to care for themselves. This aggressive focus on removal despite manifest ill health showed a disturbing lack of concern for the welfare of removees. The Department undertook inappropriate measures to effect the removal of those who were seriously ill. Some service providers were forced to use court interventions in order to stop removal, increasing costs for both the services and the Department. Service providers felt the Department's approach to removal failed to consider the impact on individuals who were incredibly vulnerable.

ATTEMPTED REMOVAL DESPITE AWAITING HOSPITALISATION

Service provider: *There was another case last year ... A man was ...called to DIMIA in [the detention centre] at about 1 o'clock in the afternoon. He thought he was going to discuss his visa. He didn't return to his compound. The guards came and started putting his possessions in a plastic bag which is the usual sign that something's up. We were contacted ... because one of our lawyers was representing this client... We worked out that he was being flown to Perth. ...I called the psychiatrist who was treating him ...and he had been in [the detention centre] the previous week and he'd put the man on suicide watch and listed him for a bed in [a hospital]...So I rang him at 9 o'clock at night and asked if he knew where his patient was, if he would be shocked to hear that his patient was being deported when he was currently on the suicide watch and a waitlist for a bed... He rang [DIMIA] ...and later I rang the Operations person and he said there will be no deportation tonight. So that man was taken off the plane in Perth and he was transferred to a psychiatric hospital... The next day the Minister ... said it was a total fantasy, there was no intention to remove... That man is still in the [detention centre], that's over 12 months, nearly 12 months ago. He's been in detention now for over six years...*

Postscript: This man has now been granted a permanent visa.

UNFIT FOR TRAVEL BUT NOT UNFIT FOR REMOVAL: LOOKING FOR A RESOLUTION

It is important to note here that fitness to travel assessments that identify someone as being unfit for travel do not mean that the individual is then considered unfit for removal and offered a permanent solution. This gap in the process has meant that seriously ill removees may wait for years for their situation to be resolved as the Department apparently waits for their health issues to resolve. Throughout this time, they live in Australia without income and, if in the community, without access to medical care.

Service providers felt that the Department maintained unrealistic expectations that the health of some individuals would improve over time, especially if they had no access to health care, thereby refusing to provide a permanent solution to their status in Australia.

DISCUSSION – PRE-REMOVAL TESTS AND “FITNESS TO RETURN”

Fitness to travel assessments do not assess the ability of an individual to survive after removal, but provide an assessment regarding the ability of an individual to undertake international travel. Fitness to travel assessments are the only point at which an individual's ill-health is assessed prior to removal and as such they operate as an accidental minimum standard for health during removal. As the only assessment of health, this offers only limited scope for assessing health against the prospect of return. Service providers felt that the ability of somebody to survive an international flight was not an adequate minimum standard for health prior to return. They felt that a more comprehensive assessment was needed to assess an individual's 'fitness to return', thereby ensuring that returnees have the possibility of achieving a sustainable return.

This issue is exacerbated by the fact that removals are the realm of officers who are fulfilling a process of law: unlike a number of other nations, there is no formal decision to remove someone. This means there is no pre-removal assessment of the whole of an individual's situation, including medical issues or issues regarding children and family ties, that may bring to light significant reasons to delay or reconsider removal. A pre-removal assessment, or 'fitness to return assessment', would strengthen the integrity of removals, and offer the removee an opportunity to have the whole of their situation recognised – including health and welfare issues that fall outside of the Refugee Convention.

The government should consider establishing an independent (non-DIAC) body to assess the health and welfare issues of returnees including but extending beyond fitness to travel assessments. This would ensure that an individual or family's context would be considered in its entirety prior to departure along with appropriate outcomes. Issues to consider in such an assessment would include health and welfare concerns, the impact on minors (especially if the return will separate family members), as well as the context on return.

Such an assessment could consider many of the issues that an asylum seeker may currently only raise through application to the Minister for intervention on discretionary grounds. Although such an assessment would add another layer to the current process, it could ease the pressure on the Minister's time and improve the confidence of the public and returnees that all the factors have been considered to achieve the best possible outcome.

A 'fitness to return assessment' might also provide the mechanism by which to assess human rights obligations if a complementary protection visa system (discussed in section 4.8) is not introduced. However, the use of such an assessment for this issue would not alleviate the current bureaucratic burden of processing both primary and review applications before human rights issues can be considered personally by the Minister.

RESPONSE OF COMMUNITY SECTOR

Service providers have undertaken some of the following activities regarding fitness to travel assessments:

- Organising and undertaking fitness to travel assessments.
- Advocating for recognition of mental health issues in fitness to travel assessments.

RECOMMENDATIONS

To ensure appropriate health assessments prior to removal, we recommend:

- 5.3.1 Fitness to travel should be assessed against clear guidelines and be consistent across medical practitioners. Fitness to travel assessments for removees should be equivalent to assessments made for the general Australian population.
- 5.3.2 The medical opinion of the treating physician should be considered as professional and independent evidence of health status.
- 5.3.3 The fitness to travel assessments of HSA should be monitored to ensure independence, rigour and a recognition of mental health issues.
- 5.3.4 The outcome of fitness to travel assessments should determine the amount of medication given to returnees, and the referrals required.
- 5.3.5 A 'fitness to return' assessment should be undertaken to assess health and welfare concerns.

5.4 Health during removal

Asylum seekers who reach the end of the asylum process in Australia are often mentally and physically exhausted by the experience, and feel unable to negotiate the stress and anxiety associated with removal. Combined with this fragile state of health is a lack of resources and support to undertake departure and

organise their needs on arrival. The asylum process ends up defeating the ultimate policy goal of being able to remove those who are not recognised as refugees.

The removal process is a very difficult undertaking for asylum seekers who are seriously ill (see Table 5.2). The physical demands of international travel can place great strain on individuals weakened from physical illnesses, while the stress and anxiety associated with return can have significant repercussions for those with mental health issues. Underlying these stressors is often a well-substantiated fear for themselves or their loved ones on return. Issues relating to the removal event itself can be identified and managed to ensure the least severe impact of removal on health and wellbeing. Service providers were aware of several Departmental policies and practices that they felt further placed their clients' wellbeing at risk during removal.

TABLE 5.2: THE REMOVAL EVENT

Aspects of the removal event that impact health	Impact on health
<ul style="list-style-type: none"> • DIAC's approach to welfare issues during removal • Use of detention • Lack of preparation for removal and farewell • Timing of removal • Use of force, including physical and chemical restraint • Treatment of removees by escorts • Medical escorts: the role of nurses and medical practitioners 	<p>International travel can be a health risk to someone with a serious illness.</p> <p>Anxiety surrounding removal compounds mental health issues.</p> <p>Removal event can trigger a 'crisis' in mental health.</p> <p>Negative impact on families:</p> <ul style="list-style-type: none"> - Higher levels of conflict due to high levels of stress and uncertainty. - Distress for children who witness family members restrained during removal. - Use of children to control behaviour of parents. - Children and families detained.

DIAC APPROACH TO WELFARE ISSUES DURING REMOVAL

Service providers felt that the overall approach of the Department demonstrated a poor understanding of how to manage welfare issues, including serious illness, throughout the asylum process and through the removal event. Compliance officers appear constrained in their ability to organise and achieve removals that would cause the least amount of distress to the removee due to a lack of familiarity of the individual's situation, past behaviour and health and welfare needs. Removals involving individuals with a serious illness, and in particular with mental health issues, were marked by a distinct lack of understanding and concern for the wellbeing of the returnees. This may be because compliance officers do not assess their clients: this is only undertaken by case workers. This lack of knowledge and concern compounded the dynamic of conflict that underlies most removals.

USE OF DETENTION

As noted above, detention is required for any person who cannot fund a voluntary return. As a result, detention is the first step in the removal journey. Removees may be detained before their removal arrangements have been made to ensure that they are available for removal when everything is ready. Some removees are taken to detention once travel arrangements have been made, and are held for a few days while preparations are finalised.

The use of detention in the removal process is a highly daunting prospect for asylum seekers facing return. This is especially true for those who have had highly traumatic experiences while held in detention at an earlier stage of the asylum process. Detention remains a significant obstacle in the removal process for many asylum seekers. Fear of detention can fuel a removee's opposition to removal, and evokes a greater sense of defiance of removal procedures.

TIMING OF REMOVAL

Although compliance officers must remove an unlawful non-citizen as soon as reasonably practicable, they are in a position to decide what is reasonable given an individual's circumstances. Service providers were pleased that the health and welfare of some removees were taken into account by compliance officers when arranging a removal. For instance, one removal was delayed to enable

the removee to have an operation that would allow them significant independence on return. They were concerned, however, that this was usually only after a long period of advocacy on the behalf of the removee by a service provider. A more flexible approach to the timing of removals could have a significant beneficial effect for seriously ill removees.

LACK OF PREPARATION FOR REMOVAL AND FAREWELL

Removees have little or no control over their own removal and are often informed of the planned departure only a short time before the travel is due to commence, if at all. For removees considered low risk, this may be 48 hours before their departure. For people considered a high risk of interrupting an effective removal, or at risk of endangering themselves or others, removal can be a surprise event (Senate Legal and Constitutional References Committee, 2006). As a result, there is often little time to pack belongings, prepare for the journey, or inform and farewell family and friends in Australia. Even with some notification, the short time span can make it difficult to organise any plans for arrival, such as initial accomodation.

This issue was noted in the recent Senate Inquiry, with a recommendation that “the Migration Act be amended to require that all prospective removees be provided with reasonable notice” (Senate Legal and Constitutional References Committee, 2006: p. 279). The lack of communication with removees about the details of removal plans needs to be improved to ensure respectful removals.

REMOVAL FROM A DETENTION CENTRE

Service provider: *...you know this in the abstract but when you see it in practice it really reinforces how there is a form of state violence involved. I mean people would be screaming as they were dragged out by a whole lot of burly officers. It's ...a violent process removing someone who doesn't want to go and often it's done by surprise...I think it's inseparable from that whole question of removal and how it's done and how people are prepared for that.*

USE OF FORCE INCLUDING PHYSICAL AND CHEMICAL RESTRAINT

Service providers were concerned about the use of force and restraint during the removal event. These concerns were based on their experiences of the initial stages of removal, and of reports from detainees and those who had already been removed. This lack of direct knowledge reflects the lack of transparency surrounding removals, which take place largely in private and controlled spaces in a way that can not be monitored by outsiders or the public. It is known that compliance officers can be confronted with extremely difficult and disruptive behaviour when removees refuse to cooperate with removal efforts. According to *MSI 408: Removal from Australia*, compliance officers are permitted to use restraints when “considered necessary for the security of the removal and the safety of the removee or the general public...Physical holds and/or restraint devices may only be used for the minimum time necessary” (Department of Immigration and Multicultural Affairs, 2005d). This can include the use of physical force to move individuals from one place to another; using restraint devices such as handcuffs to control physical movement; and, with approval, using mouth-taping in exceptional circumstances to prevent injury from biting.

Some service providers were concerned that forms of chemical restraint are used during the removal process, but given the difficulties in monitoring departures, there is little evidence to prove or disprove these concerns. The use of chemical restraint has previously been reported in some cases (Edmund Rice Centre for Justice & Community Education, 2004; Masters, 2000). A Senate Inquiry in 2000 recommended “an inquiry be undertaken into the use of sedation and other means of restraint in ... removal” (Senate Legal and Constitutional References Committee, 2000: p. 324). This inquiry has not been undertaken. Current Department policy is that medication must not be used as a means of restraint. This is articulated in *MSI 408*: “If a medical practitioner prescribes medication (including

sedatives) to a detainee, the matter is one between the patient and medical practitioner. Neither DIMIA nor escorts are to request the administration of sedatives to a removee/deportee” (Department of Immigration and Multicultural Affairs, 2005d). However, there is a fine boundary between the use of medication for restraint, and the use of medication to manage the outbursts of someone who is mentally unwell. Given the level of mental health issues that are evident in asylum seekers in the final stages of the asylum process, this overlap may create a grey area in which medication may be used for medical purposes while facilitating the removal process.

USE OF FORCE AND RESTRAINTS IN REMOVAL

In December 2004, a passenger on a flight witnessed a man being removed. The woman’s account was reported in the media (Jackson, 2005a). This is an excerpt of her account from a radio interview (Barraud, 2005):

He was being dragged onto the plane against his will, with heaps of restraints, and he was handcuffed and chained to his waist, where there was a restraint, and he also had leg cuffs on. But probably the most shocking was he had gaffer tape around his mouth, but round and round several times, and it was so tight that it was distorting the shape of his face, really heavy, heavy tape. And I just saw him looking very distressed before they forced him into his seat, and put a blindfold on him and covered his handcuffs with a blanket. When they first sat him down, they put one of those flight masks over his eyes, they took that off after a while but certainly when he was first put on the plane, they blindfolded him.

TREATMENT OF REMOVEES BY ESCORTS

Service providers felt the use of force and restraint tactics reflected a culture of antagonism and control. The welfare and dignity of removees is left to one side in the pursuit of completing a successful removal. One report has noted the lack of dignity and respect shown towards returnees during the journey: many found the removal experience degrading and humiliating (Edmund Rice Centre for Justice and Community Education, 2006). Some removees reported that they were denied toilet access during flight, or had the toilet door kept open by their escorts. They were not allowed to talk to anyone during the removal. Service providers were especially aware of these issues when families with children were being removed. They were concerned about the impact on children of witnessing the use of force and restraint on their family members. Service providers were particularly concerned at the reports that children had been used to ensure parent’s full compliance with removal procedures, such as holding young children and threatening to depart without the parent.

MEDICAL ESCORTS: THE ROLE OF NURSES OR MEDICAL PRACTITIONERS

MSI 408 recognises that removees with a mental illness or serious medical attention may need the assistance of a medical escort to travel safely (Department of Immigration and Multicultural Affairs, 2005d). Medical practitioners or nurses including psychiatric nurses may be engaged on the advice of the medical doctor who undertook the fitness to travel assessment, or another medical doctor who has the person’s up to date medical history. Medical escorts are to be given clear guidelines to ensure the removee will be under close observation and receive the necessary medication, nutrition and assistance with hygiene until arrival at the destination.

It is important that the health and wellbeing of removees is supported through the removal process by the presence of a medical escort. However, it is challenging to acknowledge that such medical care may not be available in the country of return. Medical escorts in the removal process confront complex ethical decisions, knowing that their actions are facilitating an event that will be detrimental to the

overall health of their patient. It can also be difficult for health professionals to ensure that patients who are removees are treated with respect and dignity, one of the basic foundations of medical ethics.

ATTEMPTED REMOVAL OF MAN WITH SEVERE MENTAL ILLNESS

In January 2006, the removal of a Turkish Kurd was stopped after the Federal Court intervened at the last minute, ruling that the removal was likely to significantly worsen the removee's severe mental condition (The Age, 2006a). The treating psychiatrist claimed the man was unfit for travel. The man was to be escorted by three police officers and a psychiatric nurse, and 140 seats had been booked on the plane to avoid disruption to other passengers.

The Minister for Immigration responded to the Court injunction, saying "[i]f we come to the state or situation where if someone can be designated as being mentally ill and not removed, I think you will find there will be a lot of people who are very stressed and therefore seeking not to be removed on that basis" (The Age, 2006b).

The Minister's statement demonstrates a great distrust of mental health diagnosis amongst returnees, focusing instead on the need for an immediate and successful removal. The Department places a high emphasis on achieving removals, and will go to great lengths to provide the apparent supports needed to ensure successful transportation of a removee (such as booking 140 seats to provide an adequate buffer between the removee and other passengers). The case study above provides an example of the extreme measures used to create conditions that may enable removal to occur for someone who is seriously ill. These measures suggest that current assessments of fitness to travel are inadequate if such measures are taken to continue with removal.

RESPONSE OF COMMUNITY SECTOR

Service providers felt they have a limited ability to remedy the impact of removal on their clients. Some of their attempts to assist asylum seekers facing removal include:

- Undertaking counselling to reconcile asylum seekers to the prospect of return, and to assist asylum seekers to prepare for removal.
- Raising funds and organising travel to allow independent return.
- Arranging for 'fitness to travel' assessments when health is at risk.
- Advocating for a delay in removal when an individual's health is at risk.

RECOMMENDATIONS

To limit the impact of the removal process on the health of asylum seekers, we recommend:

- 5.4.1 Implementing case management of asylum claims all the way through the removal event.
- 5.4.2 Developing minimum standards of care for the removal process.
- 5.4.3 Developing a culture of respect and dignity towards asylum seekers amongst personnel undertaking removals, and ensuring sensitive interactions with clients.

5.5 Health on arrival

Service providers were concerned about the health and wellbeing of clients on arrival in their country of return (Table 5.3).

TABLE 5.3: HEALTH CARE ON ARRIVAL IN COUNTRY OF RETURN

Aspects of the arrival that impact health	Impact on health
• Lack of handover of welfare and medical care to appropriate organisation in country of return	Seriously ill removees are left vulnerable and without basic support on arrival. Interrogation can lead to further mental and physical deterioration.
• Lack of control of travel documentation by removee	Anxiety regarding on arrival issues can compound mental health issues.

HANDOVER OF CARE ON ARRIVAL

Service providers were concerned about the lack of arrangements made for removees at their destination. They were distressed by the experiences of seriously ill clients who had been left to their own devices in the airport of the country of return. Individuals and families had been released from the custody of their escorts without the money or assistance to arrange for their immediate needs such as food, transportation and on arrival accommodation. Few service providers could identify a removal situation in which they were aware of on arrival arrangements made by DIAC for their client. Given the hasty nature of most removals, including the lack of notification given to most removees and their service providers, this situation left removees vulnerable and destitute without basic on arrival support.

This issue was highlighted in the recent inquiries following the accidental removal of an Australian citizen, Ms Vivian Alvarez Solon⁶, to the Philippines (Commonwealth Ombudsman, 2005; Senate Foreign Affairs Defence and Trade References Committee, 2005a, 2005b). Ms Solon had been taken into immigration detention following her admission to a hospital in Queensland. She was still recovering from the injuries sustained from a physical trauma and was mentally unwell. Her mental incoherence led to her mistaken identification as an unlawful non-citizen. Following a fitness to travel assessment by a locum medical practitioner, she was removed to the Philippines on 20 July 2001. She was escorted on her journey by a female member of the Queensland police force. No arrangements had been made for her reception in Manila, and it seems Qantas ground staff eventually noticed she was without support and connected her with a local welfare organisation represented at the airport. It is unclear at what stage the escort left the company of Ms Solon. The welfare organisation took her to a nearby hospital and paid for an examination. Once released, they arranged for her board and lodging for two days until she was moved into the care of another charity, where she was located on 12 May 2005.

The Commonwealth Ombudsman concluded that “the Inquiry considers that, in view of her poor physical and mental health and the lack of known family support, the arrangements made for Vivian’s reception and welfare on arrival in Manila were inadequate” (Commonwealth Ombudsman, 2005: p .61).

Since the inquiries into this matter, the Department has re-written its removal procedures in MSI 408 (Department of Immigration and Multicultural Affairs, 2005d). The new procedures include instructions to officers to ensure that the needs of removees who are vulnerable or have special needs are considered and appropriately met. This may include the use of special escorts, arrangements for individuals to be met upon their arrival by medical and/or welfare staff and consultation with relevant welfare bodies. Such arrangements might be needed for persons with serious health issues, unaccompanied minors, family groups, pregnant women, or those in destitute circumstances.

⁶ Vivian used various combinations of her surnames Solon, Alvarez and Young.

LACK OF HANDOVER OF CARE

Service provider: *I don't know [of DIAC arranging support on-arrival]. With the guy ... who was sent back with the psych nurses [as medical escorts], nothing was organised for him that I know of. It was organised that they could get him there safely without disruption ... but nothing was organised for him on arrival ... It's out of sight, out of mind. They don't care whether they survive.*

As further discussed below, there are some safety issues that must be negotiated when arranging welfare or medical handover on arrival. Asylum seekers being returned to some states have valid fears for their safety on arrival as a result of having been absent from their country of origin for long periods without authority. Some countries, such as Iran and Syria, have a history of targeting returning asylum seekers on arrival for imprisonment and interrogation. This should be considered before contacting agencies in the country of return and to reduce the risk to the removee and any escort.

CONTROL OF TRAVEL DOCUMENTATION AT PORT OF ENTRY

Current procedures for escorting removees do not ensure travel documents are returned to the removee prior to movement through immigration at the port of entry. This is of concern for those removees who are fearful of interrogation regarding their time outside their country of the return. Escorts who accompany removees through the immigration process in the country of return may put the health and wellbeing of removees at risk when there are valid dangers of a punitive response for those returning citizens who have sought refugee protection in another country.

Escorts retain control of documentation to ensure that the removee successfully enters the country of return. Airline staff, aware of non-escorted removals, may also maintain custody of the removee's travel documents until immigration clearance for fear the removee will destroy the documents before passing through the immigration check point. As airlines can be fined for passengers who arrive in a country without valid travel documentation, this action is done to protect the airline from potential fines. This concern should be tempered by an understanding of the potential risk of retribution that may befall the individual removee if their status as a removee is revealed to the authorities in the country of return.

Travel documentation should be returned to removees before entering the immigration check point in any situation where they are endangered on return. This should be clarified with officers, escorts and airline staff to ensure the safety of returnees is not jeopardised.

RESPONSE OF COMMUNITY SECTOR

Service providers have few opportunities to support removees on arrival. Often they are not notified of a removal until after it has occurred. However, some service providers have attempted to assist by:

- Trying to arrange someone to meet the removee at the airport if they are aware of the details of the removal.
- Trying to arrange on-arrival medical support or hospital admission if they are aware of the details of the removal.

RECOMMENDATIONS

To ensure appropriate provisions are made for the health of asylum seekers on arrival, we recommend:

- 5.5.1 Organising appropriate handover arrangements in destination country if no issues regarding safety are evident.
- 5.5.2 Ensuring removees retain control of their travel documentation when proceeding through immigration at the port of entry. Travel documentation should be withheld only as a last resort.

5.6 Health after return

Service providers were aware of a variety of issues in the country of return that would impact on the health and wellbeing of seriously ill clients (Table 5.4). Many countries of return lack a health system that has the expertise, equipment and medicine to treat illnesses that can be treated in Australia. Some countries are unable to provide even good quality primary health care services. This issue is exacerbated by poverty at the individual and state level, as well as by ongoing conflict and violence. For some returnees, lack of family and social networks in the country of return means they will face a serious illness without basic care and support.

TABLE 5.4: HEALTH IN COUNTRY OF RETURN

Aspects of ongoing living situation that impact health	Impact on health
<ul style="list-style-type: none"> • Lack of adequate health care in country of return • Lack of access to medications in country of return • Extreme poverty at individual and state level • Living in areas of violent instability including war and civil conflict • Lack of primary carer and support networks 	<p>Deterioration of health due to limited access to and quality of health care system.</p> <p>Deterioration of mental health due to high levels of stress, and lack of mental health care.</p> <p>Deterioration of health due to poverty.</p> <p>Deterioration of health due to impact of violence.</p> <p>Deterioration of health due to lack of a carer and/or social support.</p> <p>Negative impact on families:</p> <ul style="list-style-type: none"> - Higher levels of conflict due to high levels of stress and uncertainty. - Demands of caring for a seriously ill family member without adequate medical support. - Minors caring for seriously ill parents.

HEALTH CARE ON RETURN

Most countries to which asylum seekers are removed have fewer resources than Australia and have not been able to invest in a sophisticated health care system. Table 5.5 provides a basic overview of health care resources in some key countries of return compared against Australia. As the comparison shows, countries of return have fewer health resources than Australia, with some countries failing to provide even basic health care coverage for their population. In addition, returnees are often unable to access the services on offer because they either cannot afford them or, in the case of those who flee to a third country, because they are illegal residents and cannot access the health care available to the local community. These problems are exacerbated in countries where ongoing conflict and turmoil have interrupted and largely destroyed health care services.

TABLE 5.5 COMPARISON OF HEALTH CARE SYSTEMS (WORLD HEALTH ORGANIZATION, 2006B)

	Population (total)	Per capita GDP (Int\$)	Per capita total expenditure on health (US\$)	Per capita government expenditure on health (US\$)	Physicians (density per 1 000 persons)	Nurses (density per 1 000 persons)	Pharmacists (density per 1 000 persons)	Number of hospital beds (per 10 000 persons)	Life expectancy – male (years)	Life expectancy – female (years)
Afghanistan	29,863,000	430	11	4	0.19	0.22	0.02	3.9	42	42
Albania	3,130,000	6,158	118	49	1.31	3.62	0.40	30.0	69	74
Australia	20,155,000	31,454	2,519	1,699	2.47	9.71	0.72	39.9	78	83
Ethiopia	77,431,000	381	5	3	0.03	0.21	0.02	–	49	51
India	1,103,371,000	1,830	27	7	0.60	0.80	0.56	6.9	61	63
Iran	69,515,000	8,367	131	62	0.45	1.31	0.09	16.3	68	72
Iraq	28,807,000	3,554	23	12	0.66	1.25	0.53	13.3	51	61
Pakistan	157,935,000	2,151	13	4	0.74	0.46	0.05	6.8	62	63
Sri Lanka	20,743,000	3,800	31	14	0.55	1.58	0.06	29.0	68	75
Turkey	73,193,000	7,688	257	184	1.35	1.70	0.32	26	69	73

Many countries of return offer little possibility for treatment of mental health issues. Individuals who have developed mental health issues during the asylum process in Australia can find themselves returned to a country that does not recognise mental health as a treatable medical condition and is without an established mental health profession. In this situation, the mental health of returnees will be left without treatment and allowed to progress without intervention.

Poor health care systems and services mean that treatment of both physical and mental health may be minimal, ineffective or inaccessible to returnees. Serious health issues can deteriorate rapidly without appropriate treatment, and the lack of health care can have devastating consequences for many returnees and their families. Service providers were aware of the inevitable tragedy that awaited some of their clients on return, and felt strongly opposed to situations where the lack of health care on return would result in their early and untimely death.

LACK OF ACCESS TO MEDICATIONS IN COUNTRIES OF RETURN

One of the consequences of the inequality of health care systems in countries of return is that medications available in Australia are either unavailable or unaffordable in countries of return. This issue covers pharmaceuticals prescribed for a range of health issues including, among others, asthma, heart disease, cancer, pain management, birth control, HIV/AIDS and sexually transmitted diseases. The lack of medications to counteract such issues will have a negative impact on health. Returnees who have been managing mental health issues with medication while in Australia will have difficulties as they experience sudden drops in dosages due to inconsistent or non-existent supplies of medication. Some countries of return may not have access to the core essential medications which form the basis of a basic health care system (World Health Organization, 2006a).

MEDICATION AFTER RETURN

Service provider: *[W]e're coming up to some real ethical dilemmas about what to do about people when they go back. At the moment I've got a case of a guy who had significant psychiatric issues who's been sent back to Iraq. ... [H]e is without medication over there because there's no ...psych services ... They had to go to Iran to try and seek better health services ...I'm ...being asked if I can fund this guy's ongoing psychiatric medication based on a piece of paper written by a doctor (who says he's a doctor but I have no independent proof) saying that it costs \$150 a packet to give him his medication and we're getting twice-a-week phone calls from the family [in Iran] saying 'You've got to help us. We've got to sort this out.' ... I've had other patients who've been sent back to their country of origin where they're on ongoing medication and I've said to them, "Look, I'll give you six months worth of medication and after that you're on your own" ...knowing full well that in some of those countries the kinds of medications I've had them on is simply not available.*

POVERTY AT THE INDIVIDUAL AND STATE LEVEL

Seriously ill asylum seekers who return to countries with few resources may face destitution on their return, especially if their ill health prevents them from being able to work. Individuals who have previously fled a country face serious difficulties in establishing a good economic footing on return. Their financial situation on return will be exacerbated by the level of destitution forced upon them while living in Australia, as many asylum seekers have not been allowed to work or receive financial support for a number of years. Consequently, many are removed without any savings, skills or resources that they can put to use on arrival. In some countries, this level of poverty will mean that obtaining the basic necessities for subsistence will be extremely difficult.

Some countries of return have few resources to support their population, and are unable to address the poor environmental health of the places in which people live. Sanitation, drinking water quality,

food supply, disease control and housing conditions are some of the major factors that impact on health (World Health Organization, 1981). Poverty is also one of the strongest factors determining mental health (World Health Organization, 2003), meaning return to situations of poverty will contribute to the further deterioration of mental health issues. This issue is exacerbated during an environmental crisis, such as a tsunami, earthquake or severe drought, that interrupts the normal structures of society and leads to a humanitarian crises such as famine and epidemics. This has been noted in previous research regarding health and return:

“Poverty has clearly been demonstrated to be one of the most important factors in affecting ill health and death from both infectious diseases and non-infectious reasons and many of the health differences between global locations are related to what are called rich-poor differences” (Gushulak, 2001: p. 318).

SITUATIONS OF ONGOING CONFLICT AND VIOLENCE

Service providers were highly disturbed by the removal of clients to countries that were in the middle of an ongoing war or violent conflict. They were particularly distressed by the removal of individuals to countries where Australia was taking part in armed conflict, such as Afghanistan and Iraq. Situations of ongoing conflict place returnees at risk of becoming victims of violent attacks or casualties of war. Ongoing conflict also presents very unstable living conditions, with threats to basic supplies such as food, water, housing and fuel. Previous research has identified returnees who have died or been injured as a result of being returned to a conflict zone (Edmund Rice Centre for Justice and Community Education, 2006).

The removal of individuals and families to countries that are in the middle of a war and without an established government places removees at high risk. In 2003, the United States Court of Appeals upheld a District Court decision that prohibited the removal of Somalis due to the absence of a functioning government. This decision was formed largely as a result of the extremely high possibility of irreparable injury as there is “no official entity which might provide even the most basic of administrative protections upon their arrival” (Ali v. Ashcroft, 2003). As a result of this class action, removals to Somalia ceased indefinitely.

LACK OF PRIMARY CARER AND SUPPORT NETWORK

Some asylum seekers do not have any family or friends left in their country of origin and they face return with the extra burden of coping with a serious illness without support. Service providers were especially concerned about seriously ill clients who were going to lose their primary carer after their removal because their carer lived in Australia. Without such support, some seriously ill asylum seekers would not be able to maintain basic daily activities: personal hygiene and nutrition may be affected if their independence and movement were inadequate to undertake basic tasks such as shopping for food, cooking, eating, washing and cleaning. This issue can also have an enormous impact on wellbeing as people are left to deal with the practical and emotional trials of a serious illness on their own.

OUT OF SIGHT, STILL IN MIND: CLIENTS WHO HAVE LEFT AUSTRALIA.

Many service providers spoke with concern about clients who had already been removed from Australia. Some continued to hear from former clients who were now overseas: in some cases there was regular contact, and in other cases they only had one-off or occasional news. The level of contact usually depended on the circumstances of those who had been returned. Service providers found it difficult when confronted with the harsh reality of life for removed clients, but also feared the worst when they did not hear from clients who had promised to keep in contact.

HEARING FROM FAMILIES WHO HAVE BEEN RETURNED.

Service provider: *The families who are in Indonesia, I hear from quite frequently. They're having a lot of trouble re-establishing themselves. It's difficult actually to hear from them. I mean, you want to know what's happened but its very hard to hear how awful it is for some people once they've returned... One of these Indonesian families, they didn't have any major health issues that I knew of here, but due to their ethnicity it's very difficult for them to access the health services and education in Indonesia and she has written to me saying they just can't afford to get access to any of those services because they don't have the money having been here for, I think they were here for eight years and not working for a lot of that, so they went back with no money and no house and so the kids haven't been able to go back to school and she has written that they just can't get to doctors and they can't do any of that.*

DISCUSSION – MINIMUM STANDARDS IN COUNTRIES OF RETURN

There are gross inequalities throughout the world and the removal of seriously ill asylum seekers from Australia brings to light this stark reality. Few ill asylum seekers could anticipate an improvement in their health as a result of removal. This is most clearly the case when they are removed to countries without basic resources, with poor health care services and with ongoing war and instability. This is exacerbated for those who will be unlikely to find someone to provide primary care as their health deteriorates.

In these particulars, asylum seekers are re-entering the unfortunate circumstances of all people who live in their country of origin. Although Australia cannot step in to take responsibility for all people living in situations of extreme poverty and violence, minimum standards for return must be established. This would not only ensure humane treatment for returnees, but also alleviate the complexity of decision making by providing clear thresholds for Departmental officers. Such thresholds should include a basic level of security including the absence of active war and violence; an operating basic health care system; and the ability to access and obtain basic resources for daily life, such as food, clean drinking water, fuel and shelter. This would also provide some measures for assessing return to a country that has recently experienced a natural disaster. In monitoring countries of return against these standards, the government could make use of the information gathered by UNHCR and non-government organisations that are already positioned to monitor the on-the-ground situations in countries of return.

Development and peace-building activities are one way in which minimum standards in countries of return may become established. Investment in infrastructure and security through development assistance can be crucial for supporting fragile societies trying to cope with the return of citizens who have previously left to seek asylum. The Australian government has previously provided financial support for development programs in countries such as Afghanistan, and this support has been expressly linked to return objectives (Vanstone, 2005). Such support, if contributing to a larger program of development and peace, has the potential to enable communities to establish stronger structures that will, in turn, support returnees as they attempt to find a place for themselves. This increases the possibility of long-term, sustainable returns of citizens (Black & Koser, 1999; Taylor, 2005b).

RESPONSE OF COMMUNITY SECTOR

Service providers have continued to play a role in the lives of some of the clients after return by:

- Staying in contact.
- Providing occasional financial support from personal funds.

RECOMMENDATIONS

To ensure return is undertaken fairly and consistently and with respect for the dignity of all

human life, we recommend:

- 5.6.1 Seriously ill individuals should only be returned if their condition can be reasonably managed in their country of return.
- 5.6.2 Individuals should not be returned to a country that is in the middle of war, or experiencing severe conflict and violence.
- 5.6.3 Individuals should not be returned to a country that is unable to meet the basic needs of its residents, such as after a crisis e.g. a tsunami, earthquake or during a famine.
- 5.6.4 The Minister should make greater use of his discretionary powers to grant a visa to somebody who is facing multiple and complex threats to their health on return.
- 5.6.5 The government should increase investment in development programs in countries of return.

5.7 Human rights, duty of care and compassion

The removal of asylum seekers who are seriously ill is a difficult situation requiring decisions along ethical and moral lines. Discussions regarding Australia's removal process can become complicated as a number of frameworks can be used to assess and understand removal policy and practice. This section aims to outline three major frameworks that assist in negotiating policies regarding removal. Firstly, we review the international expectations regarding the removal of seriously ill asylum seekers that have been developed in line with human rights legislation. We then examine our responsibilities towards asylum seekers while they are in Australia, and discuss the implications for removal when this duty of care is not fulfilled. We finish by discussing the moral codes used by individuals to assess the treatment of people who are vulnerable as a result of illness, poverty and danger, and the ways this leads us to develop compassionate responses as a society.

HUMAN RIGHTS PROTECTIONS AND LIMITATIONS FOR SERIOUSLY ILL REMOVEES

Australia's interpretation of its international responsibilities towards individuals who are removed is currently limited to discretionary intervention when removal would lead to a violation of certain core human rights. As these rights are not part of our federal legislation, the exact situations in which this imposes an obligation of *non-refoulement* have not been clearly determined in the Australian context. In Europe, the European Court of Human Rights has tested *non-refoulement* obligations for human rights that exist in European legislation – most notably through cases relating to the *European Convention on Human Rights* (ECHR). European legal precedents preventing removal have been a result of the applicant demonstrating that their circumstances on return would amount to inhuman or degrading treatment, which is prohibited by Article 3 of ECHR.

In the case of *D v the United Kingdom*, the definition of 'inhuman and degrading treatment' was tested against the circumstances of a man in the terminal stages of AIDS facing deportation to St Kitts and Nevis following completion of a prison sentence in the UK. In their unanimous decision, the judges decided in favour of the applicant, concluding that "his removal would expose him to a real risk of dying under most distressing circumstances and would thus amount to inhuman treatment" (*D v the United Kingdom*, 1997). In arriving at this judgment, the Court stressed the "exceptional circumstances" and the "dramatic consequences" of an expulsion, and referred to multiple aspects of the man's situation, including:

- the acute mental and physical suffering he would experience;
- the level of infections he would contract due to lack of shelter and proper diet and exposure to sanitation problems;
- lack of evidence that his sole relative in St Kitts would support or attend to him;
- lack of evidence of any other form of support;
- lack of evidence of guarantee of a bed in one of the two hospitals on the island.

Six years later, a decision regarding a similar case assisted with developing a more comprehensive interpretation of the human rights of return. In *Arcila Henao v. the Netherlands*, a man facing deportation following a prison sentence argued his expulsion to Colombia would constitute inhuman and degrading treatment because he would be unable to continue medical treatment for HIV and Hepatitis B (Henao v The Netherlands, 2003). Due to his treatment with antiretroviral medication while in prison, his condition was stable and he was assessed as being fit to travel. The Netherlands' Medical Advice Bureau noted that if the treatment were stopped, "it could be expected that his health would relapse (reduced immunity and opportunistic infections), giving rise to an acute medical emergency which, failing treatment, would be of a permanent character" (Arcila Henao v The Netherlands, 2003). The Bureau also noted that while the treatment was in principle available in Colombia, there could be delays in the delivery of medication and possible waiting lists of up to a year to access public health care institutions. The man had a number of family members living in Colombia. In an unanimous decision, the Court concluded that, unlike the situation in *D v the United Kingdom*, "it does not appear that the applicant's illness has attained an advanced or terminal stage, or that he has no prospect of medical care or family support in his country of origin...Although the Court accepts the seriousness of the applicant's medical condition, it does not find that the circumstances of his situation are of such an exceptional nature that his expulsion would amount to treatment proscribed by Article 3 of the Convention" (Henao v The Netherlands, 2003: p. 8).

These two cases provide some insight into the difficult negotiation of the human rights limitations regarding removal. ECHR decisions have placed some definite boundaries on the extent to which poverty and lack of resources, including health care, might prevent removal, while ensuring that the complex situations of individuals who face an overwhelming multitude of adversities on return are protected from an inhuman situation. These decisions have provided only a starting point for negotiating these dilemmas for the spectrum of situations which exist on return. As Rohl (2005) notes, "At the moment, the vagueness of what constitutes sufficient suffering, a real risk, or 'exceptional circumstances', leave both potential applicants and states uncertain about the extent of their rights and obligations" (p. 32).

Although Australia does not take responsibility for the human rights laid out in the ECHR, the deliberations regarding Article 3 provide an important perspective on how Australia can negotiate the complex issue of assessing which situations fall below a minimum standard of treatment towards another human being. These are the types of decisions that are currently negotiated by the Minister under his discretionary powers. In a few instances, the convergence of particular health issues with forms of persecution have led to an assessment under the Refugee Convention. This has occurred in instances where health care is not provided to people with particular illnesses (as the case with people with HIV in Nepal (Refugee Review Tribunal, 2003)) or where the behaviour and psychiatric relapse of a returnee interrogated on return would lead authorities to suspect anti-government opinions (Refugee Review Tribunal, 1996). Beyond these instances of persecution, there are times when the combination of an individual's circumstances on return would amount to a violation of human rights, yet Australia does not commit to protect individuals from such situations on return. In these circumstances, our responsibilities to an individual outweigh our rights as a state to remove non-citizens. Australia's current system does not provide asylum seekers or public servants with a strong framework by which to negotiate this difficult and confronting dilemma in a fair and consistent manner.

DUTY OF CARE DURING THE ASYLUM PROCESS AND RESPONSIBILITIES FOR POST-REMOVAL CARE

Australia has a duty of care towards asylum seekers while they are in Australia: for those in the community, this is mandated by international human rights legislation that permeates state boundaries to ensure that asylum seekers have access to health care, a basic livelihood and respect and dignity; for those in detention, there is a stronger duty of care that comes into play as a result of placing people's

lives within the control of an institution established by the government. In each of these situations, there is an underlying responsibility to ensure that the policies set up and maintained by the Australian government do not cause undue harm to those individuals and groups who must experience the daily reality these policies in their lives.

The Australian government has created an asylum system that does not fulfil our duty of care towards asylum seekers while they are in Australia. The policies and procedures designed to process and manage those who seek asylum in Australia have been found to have a serious and detrimental impact on the health and wellbeing of this vulnerable population. These impacts were clearly described in the previous chapter. If asylum seekers were not harmed through the process of seeking asylum in Australia, then our duty of care for them would have been fulfilled and this, in turn, would mean our responsibility towards them relinquished on removal. As it stands, the impact of the government's policies introduces a greater responsibility for their welfare after removal. In particular, Australia must take responsibility for those asylum seekers whose health has deteriorated as a result of the lack of care while in Australia. This responsibility includes ensuring that the services and care needed to manage the health impacts are available after removal.

The current asylum process is self-defeating when it comes to the final outcome: if an asylum seeker is accepted as a refugee and granted a visa for Australia, then the asylum process has caused harm to a future resident of Australia, and Australia will bear the costs associated with caring for that person as they attempt to live with, or recover from, the negative impact on their wellbeing. For those asylum seekers who are removed at the end of the asylum process, the impact on health and wellbeing creates greater difficulties during removal and creates responsibilities that impact on options for return, as they must be predicated on access to appropriate support and health care services.

In the second ECHR case outlined above (*Arcila Henao v the Netherlands*), the medical treatment provided to the applicant while in the Netherlands had retarded the development of a serious illness. The result was that the applicant was considered fit to travel at the point of removal. This assessment, along with other pertinent factors regarding his situation on return, meant that despite the difficulties that awaited him, he was in a position to try and make the best of his life after removal. This outcome largely depended on his treatment while in the Netherlands. This situation contrasts against the development of ill health experienced by many removees who have been unable to access the medical care while in Australia.

Some academics and development workers have argued that the return of asylum seekers and refugees can act as a tool of development for countries in need of stabilisation and aid (Cohen, 1998; Juergensen, 2002; Sperl, 2002). Asylum seekers who return to a country that has experienced war and instability can be in a position to bring new ideas and resources into action upon their return, and as such can bring about development processes. The Australian asylum system, however, works against this possibility by undermining the health and livelihood of many asylum seekers. This is suggested by Corlett's (2005) observation that, when compared against returnees from Australia, Afghan asylum seekers returning from Europe seemed in a better frame of mind to make the most of opportunities on return. Fulfilling the human rights of asylum seekers while they are in Australia will allow them to return with the personal and economic resources to contribute on return.

RESPONDING TO THE SUFFERING OF OTHERS: BEING LED BY COMPASSION

The previous two sections have outlined the human rights obligations, and duty of care responsibilities, that dictate certain standards when it comes to removal. However, these are not the only standards by which we can assess our treatment of asylum seekers who are being removed. Individuals make use of a personal moral framework to assess the actions of the Australian government undertaken on behalf of its citizens. These moral codes often expand well beyond the level of assistance and compassion that is prescribed by human rights and duty of care obligations.

From this perspective, Australia could be much more humane and compassionate towards removees who are suffering from serious illness. Aware of the painful and distressing circumstances that await those with a serious illness, many service providers felt that Australia could easily offer ongoing healthcare and support to such individuals. Given our position of incredible wealth, service providers felt that the government's great reluctance to offer relief to individuals in this situation displayed an acute lack of compassion or concern. A more compassionate response is reflected in the recommendations of humanitarian organisations that propose seriously ill people should not be removed unless they can access real medical treatment upon return (Amnesty International et al, 2005).

Arguments for a more compassionate approach are often countered by concerns that a compassionate response for one person will lead to an inundation by hordes of citizens from other nations who want to manipulate the immigration system to access our health care services. It is difficult to establish the likelihood of this scenario, but we are not, and have never been, inundated to an extent that would compromise the Australian health and welfare system. Our compassionate response for an individual who is currently needing our assistance should not be negated or neglected due to our concern that we may be unable to continue this response in the future.

Finland is one nation that has taken a more compassionate approach towards seriously ill removees:

"In Finnish legal praxis it has become established practice for courts to quash deportation and allow continued residence if the person is seriously ill and has lived in the country for a long time...When special circumstances barring deportation are considered, application of the principles of proportionality and equity within the framework of overall legal discretion require that the weight given to the grounds for deportation should vary in accordance with the severity of the illness from which the person suffers. The more serious the illness is, the less weight should be given to the grounds for deportation in the particular case" (Traskelin, 2001: p. 339).

Finland has recognised that, as a wealthy country that receives only a small proportion of asylum claims in Europe, they have the capacity to establish a humane response to those suffering from serious illness: "Legal praxis had already adopted a position that it was unreasonable, in a deportation situation, to cut a person off from hospital care or medical care requiring repeated treatment" (Traskelin, 2001: p. 341). This more compassionate stance moves the state's response to seriously ill removees beyond the obligations imposed by human rights legislation. This example demonstrates that a nation-state can establish a compassionate and consistent response towards those who are seriously ill without diminishing the quality of the health system for its citizens.

WHAT WE CAN DO IS WHAT WE SHOULD DO

Service provider: *I'd just like to see it all done in a much more systematic way ... People should be got to a point not just that they can travel but they can actually cope on their return and that there's things in place ... I think we do have...a duty of care to people who are deported because they've been with us and we can't just shove them out, and say, 'Well, they're no longer of any concern'. That's just too easy. I think the argument is 'Oh, well, once they're out then...they're the receiving government's responsibility' but I just don't think the ethics of it are as straight forward as that. We have been in a position where we could have helped them and we didn't. We could've done more and I think that's the measure of whether we've done the right thing or not.*

5.8 Conclusion: Healthier removals?

The removal of seriously ill asylum seekers presents a situation in which Australia displays its strengths and weaknesses in respecting human rights, promoting health and treating vulnerable strangers with dignity and compassion. This chapter has outlined the high personal costs experienced by seriously ill asylum seekers who are removed, and the aspects of government policy and practice that could be amended to improve the process and ensure a healthier outcome for asylum seekers, service providers and DIAC compliance staff. The recommendations that have been included aim to outline opportunities to establish more compassionate responses to those with a serious illness without compromising the government's control over the movement of people to and from Australia. As such, the recommendations' overall impact are to:

1. Improve the current levels of health amongst asylum seekers who have completed the asylum application process;
2. Ensure more comprehensive assessments of health and welfare are incorporated in decisions regarding removal;
3. Minimise the impact of the removal process on the health and wellbeing of removees.

These aims work towards establishing a more humane system that continues to implement removal as part of the asylum regime. The recommendations have also been designed to encourage an approach that is both preventative and proactive, with the hope that this will produce a less adversarial stance between the parties involved in removals.

This chapter has outlined the ways in which the removal process impacts on, and responds to, asylum seekers with a serious illness. The limited opportunities for asylum seekers to undertake an independent and voluntary removal were outlined in section 5.1, and it was noted that this can have the potential to create an adversarial dynamic that in turn can lead to unnecessary instances of forced removal. There are several discrepancies in health care access for seriously ill asylum seekers who are awaiting removal, as seen in section 5.2, and this can compromise health and wellbeing as removees face their departure from Australia. The physical and mental impact of this can hinder the progress of a smooth removal and introduce greater responsibility for care on return. Inconsistencies in fitness to travel assessments raised serious concerns about the level of health considered appropriate to undertake international travel. These assessments were contrasted against the level of health required to survive on return, which might be captured in a standard of health assessing 'fitness to return'.

The removal event itself was examined in section 5.4 to investigate the ways in which health is both supported and compromised during the removal process. A greater awareness of welfare issues was considered a vital step in ensuring the removal process had a minimal impact on health and wellbeing. In particular, DIAC was encouraged to undertake a more flexible approach to the process by limiting the use of detention, allowing time for preparation and farewells, timing removal in response to treatment regimes, and ensuring that compliance officers and escorts develop a culture of respect towards removees that ensures their personal dignity. Section 5.5 demonstrated the clear need for Australia to ensure that the care and responsibility of a seriously ill removee is passed on to an appropriate individual or institution on arrival, while ensuring that control of travel documentation does not inadvertently identify a removee for interrogation by authorities in countries of return.

The health care available in countries of return was described to give an overview of some of the conditions that await removees. Seriously ill removees often face situations of inadequate or inaccessible health care, and this has obvious consequences for health. Some countries are also unable to provide for the basic needs of their citizens due to extreme poverty, natural disaster or ongoing violence and war. The impact of these conditions on those who are seriously ill can be exacerbated if they do not have anyone providing personal support and care. These issues might be addressed in part by establishing minimum standards of return that recognise some fundamental thresholds which must be met to provide the basic necessities for supporting human life.

In an ideal world, this complex and confronting situation would not arise. However, the global inequalities in health, wealth and security are historical realities that will continue to haunt those who are aware of the tragedies that befall the less fortunate. The current system means that this tragic reality is compounded by the actions of the Australian government. Removing asylum seekers who are seriously ill is commonly justified amongst Western asylum nations: removing those whose illness has been cultivated, or even induced, by the actions of countries of asylum is a neglect of responsibility for those who bear the brunt of harmful policy. When the most vulnerable people in our community – such as those who are seriously ill – are neglected, that is an indictment of our society whether it is a human rights transgression or not.

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